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Canada Health Act

Annual Report
2006–2007

Canada

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Minister of Health Ministre de la Santé

The Honourable/L'honorable Tony Clement

Ottawa, Canada K1A 0K9

Her Excellency, the Right Honourable Michaëlle Jean,
Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year that ended March 31, 2007.

Tony Clement

Canada

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Introduction

Canada has a predominantly publicly financed and administered health care system. The Canadian health insurance system is achieved through 13 interlocking provincial and territorial health insurance plans, and is designed to ensure that all eligible residents of Canada have reasonable access to medically necessary hospital and physician services on a prepaid basis, without direct charges at the point of service.

The Canadian health insurance system evolved into its present form over more than five decades. Saskatchewan was the first province to establish universal, public hospital insurance in 1947 and, ten years later, the Government of Canada passed the *Hospital Insurance and Diagnostic Services Act* (1957) to share in the cost of these services. By 1961, all the provinces and territories had public insurance plans that provided universal access to hospital services. Saskatchewan again pioneered in providing insurance for physician services, beginning in 1962. The Government of Canada adopted the *Medical Care Act* in 1966 to cost-share the provision of insured physician services with the provinces. By 1972, all provincial and territorial plans had been extended to include physician services.

In 1979, at the request of the federal government, Justice Emmett Hall undertook a review of the state of health services in Canada. In his report, he affirmed that health care services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the accessibility of care. This report, and the national debate it generated, led to the enactment of the *Canada Health Act* in 1984.

The *Canada Health Act*, Canada's federal health insurance legislation, defines the national principles that govern the Canadian health insurance system, namely, public administration, comprehensiveness, universality, portability and accessibility. These principles are symbols of the underlying Canadian values of equity and solidarity.

The roles and responsibilities for Canada's health care system are shared between the federal and provincial/territorial governments. The provincial and territorial governments have primary jurisdiction in the administration and delivery of health care services. This includes setting their own priorities, administering their health care budgets and managing their own resources. The federal government, under the *Canada Health Act*, sets out the criteria and conditions that must be satisfied by the provincial and territorial health insurance plans for them to qualify for their full share of the cash contribution available under the federal Canada Health Transfer.

On an annual basis, the federal Minister of Health is required to report to Parliament on the administration and operations of the *Canada Health Act*, as set out in section 23 of the Act. The vehicle for so doing is the *Canada Health Act Annual Report*. While the principal and intended audience for the report is parliamentarians, it is a readily accessible public document that offers a comprehensive report on insured services in each of the provinces and territories. The annual report is structured to address the mandated reporting requirements of the Act—its scope does not extend to commenting on the status of the Canadian health care system as a whole.

Health Canada's approach to the administration of the Act emphasizes transparency, consultation and dialogue with provincial and territorial health care ministries. The application of financial penalties through deductions under the Canada Health Transfer is considered only as a last resort when all options to resolve an issue collaboratively have been exhausted. Pursuant to the commitment made by premiers under the 1999 Social Union Framework Agreement, federal, provincial and territorial governments agreed through an exchange of letters, in April 2002, to a Canada Health Act Dispute Avoidance and Resolution (DAR) process. The DAR process was formalized in the First Ministers' 2004 Accord. Although the DAR process includes dispute resolution provisions, the federal Minister of Health retains the final authority to interpret and enforce the *Canada Health Act*.

For the most part, provincial and territorial health care insurance plans not only meet the criteria and conditions of the *Canada Health Act*, in many cases they restate the principles of the Act in provincial and territorial laws and regulations.

Currently, the most prominent concerns with respect to compliance under the *Canada Health Act* relate to patient charges and queue jumping for medically necessary health services at private clinics. Health Canada has made these concerns known to the provinces that allow these charges.

CHAPTER 1

Canada Health Act Overview

This section describes the *Canada Health Act*, its requirements and key definitions under the Act. Also described are the regulations and regulatory provisions of the Act and the interpretation letters by former federal Ministers of Health Jake Epp and Diane Marleau to their provincial and territorial counterparts that are used in the interpretation and application of the Act.

What is the Canada Health Act?

The *Canada Health Act* is Canada's federal legislation for publicly funded health care insurance. The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The Act establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive the full federal cash contribution under the Canada Health Transfer (CHT).

The aim of the Act is to ensure that all eligible residents of Canada have reasonable access to medically necessary services on a prepaid basis, without direct charges at the point of service for such services.

Key Definitions Under the Canada Health Act

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the Act as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the Act include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Insured health services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the Act and include medically necessary in- and out-patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required; nursing service; laboratory, radio-logical and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the Act are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Requirements of the Canada Health Act

The *Canada Health Act* contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash entitlement under the CHT. They are:

- five program criteria that apply only to insured health services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health services.

The Criteria

1. Public Administration (section 8)

The public administration criterion, set out in section 8 of the *Canada Health Act*, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

2. Comprehensiveness (section 9)

The comprehensiveness criterion of the Act requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services that require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health services.

4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from his/her province or territory.

5. Accessibility (section 12)

The intent of the accessibility criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).

In addition, the health care insurance plans of the province or territory must provide:

- reasonable compensation to physicians and dentists for all the insured health services they provide; and
- payment to hospitals to cover the cost of insured health services.

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

1. Information (section 13(a))

The provincial and territorial governments shall provide information to the Minister of Health as may be reasonably required, in relation to insured health services and extended health care services, for the purposes of the Act.

2. Recognition (section 13(b))

The provincial and territorial governments shall recognize the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the *Canada Health Act*, which discourage extra-billing and user charges for insured health services in a province or territory, are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory in accordance with the Extra-billing and User Charges Information Regulations (described below).

Extra-billing (section 18)

Under the Act, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e., a surgical-dentist providing insured health services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician were to charge patients any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing.

Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore contrary to the accessibility criterion.

User Charges (section 19)

The Act defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, that fee would be considered a user charge. User charges are not permitted under the Act because, as is extra-billing, they constitute a barrier or impediment to access.

Other Elements of the Act

Regulations (section 22)

Section 22 of the *Canada Health Act* enables the federal government to make regulations for administering the Act in the following areas:

- defining the services included in the Act definition of "extended health care services";
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require, and the times at which and the manner in which that information may be provided; and
- prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

To date, the only regulations in force under the Act are the Extra-billing and User Charges Information Regulations. These regulations require the provinces and territories to provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied. They must also provide financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex A.)

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the Act, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT. In plain terms, when it has been determined that a province or territory has allowed $500,000 in extra-billing by physicians, the federal cash contribution to that province or territory will be reduced by that same amount.

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the Act is subject to a discretionary penalty. The amount of any deduction from federal transfer payments under the CHT is based on the gravity of the default.

The *Canada Health Act* sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

Excluded Services and Persons

Although the *Canada Health Act* requires that insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set out in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- services that fall outside the definition of insured health services; and
- certain services and groups of persons are excluded from the definitions of insured services and insured persons.

These exclusions are discussed below.

Non-insured Health Services

In addition to the medically necessary hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services and optometric services.

The additional services provided by provinces and territories are often targeted to specific population groups (e.g., children, seniors or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court and cosmetic services.

Excluded Persons

The *Canada Health Act* definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programs.

As well, other categories of residents such as landed immigrants and Canadians returning to live from other countries may be subject to a waiting period by a province or territory. The Act stipulates that the waiting period cannot exceed three months.

In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., refugees) or under the workers' compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the Act and is not intended to constitute differences in access to publicly insured health care.

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former federal ministers of health to their provincial and territorial counterparts. Both letters are reproduced in Annex B of this report.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Minister of Health and Welfare Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the Act.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent that clarify the Act's criteria, conditions and regulatory provisions. These clarifications have been used by the federal government in assessing and interpreting compliance with the Act. The Epp letter remains an important reference for interpreting the Act.

A copy of Minister Epp's letter is included in Annex B of this report.

Marleau Letter — Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the September 1994 federal/provincial/territorial meeting of health ministers in Halifax, all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995, to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the Act includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

A copy of Minister Marleau's letter is included in Annex B of this report.

Dispute Avoidance and Resolution Process

In April 2002, then-federal Minister of Health A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the Act, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on Act-related issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either minister of health involved may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

A copy of Minister McLellan's letter is included in Annex C of this report.

CHAPTER 2

Administration and Compliance

Administration

In administering the *Canada Health Act*, the federal Minister of Health is assisted by Health Canada policy, communications and information officers located in Ottawa and in the six regional offices of the Department, and by lawyers with the Department of Justice.

Health Canada works with the provinces and territories to ensure that the principles of the Act are respected and always strives to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

The Canada Health Act Division is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and is responsible for administering the Act. Officers of the Division located in Ottawa and in regional Health Canada offices fulfill the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charges provisions of the Act;
- working in partnership with the provinces and territories to investigate and resolve compliance issues and pursue activities that encourage compliance with the Act;
- informing the Minister of possible non-compliance and recommending appropriate action to resolve the issue;
- developing and producing the *Canada Health Act Annual Report* on the administration and operation of the Act;
- developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to share information;
- collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- disseminating information on the Act and on publicly funded health care insurance programs in Canada;
- responding to information requests and correspondence relating to the Act by preparing responses to inquiries about the Act and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media;
- conducting issue analysis and policy research to provide policy advice;
- collaborating with provincial and territorial health department representatives on the recommendations to the Minister concerning the interpretation of the Act; and
- collaborating with provincial and territorial health department representatives through the Interprovincial Health Insurance Agreements Coordinating Committee (see below).

Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee and provides a secretariat for the Committee. The Committee was formed in 1991 to address issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the *Canada Health Act.*

The within-Canada portability provisions of the Act are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and signing them is not a requirement of the Act.

Compliance

As mentioned in Chapter 1, the provinces and territories must comply with the criteria and conditions of the *Canada Health Act* to receive the full amount of the Canada Health Transfer (CHT) cash contribution (previous to April 1, 2004, the cash contribution was payable under the Canada Health and Social Transfer). The following section outlines how Health Canada determines provincial/territorial compliance.

Health Canada's approach to resolving possible compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to administering and interpreting the *Canada Health Act* have been addressed and resolved without resorting to deductions.

Health Canada officials routinely liaise with provincial and territorial health ministry representatives and health insurance plan administrators to help resolve common problems experienced by Canadians related to eligibility for health insurance coverage and portability of health services within and outside Canada.

The Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the Act. Sources for this information include: provincial and territorial government officials and publications; media reports; and correspondence received from the public and other non-government organizations. Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate action. Verifying the facts with provincial and territorial health officials may reveal issues that are not directly related to the Act, while others may pertain to the Act but are a result of misunderstanding or miscommunication, and are resolved quickly with provincial assistance. In instances where a *Canada Health Act* issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff, then discuss the issue and its possible resolution with provincial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, is it brought to the attention of the federal Minister of Health.

Compliance Issues

For the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the *Canada Health Act*. However, some issues and concerns remain. The most prominent of these relate to patient charges and queue jumping for medically necessary health services at private clinics.

The Act requires that all medically necessary physician and hospital services be covered by the provincial and territorial health insurance plans, whether the services are provided in a hospital or in a facility providing hospital care. There are concerns about queue jumping and charges to insured persons at private surgical clinics in Quebec and British Columbia, for services that are covered under their respective provincial health insurance plans. Patient charges and queue jumping at private diagnostic clinics also remains an issue in some provinces where private clinics are charging patients for medically necessary services and allowing them to jump the queue for insured health services.

During 2006–2007, some outstanding concerns under the Act were resolved. In September 2006, the British Columbia Health Minister ordered certain hospitals in British Columbia to "cease and desist" from the practice of allowing queue-jumping for insured diagnostic services.

In January 2007, Quebec took action to discourage certain clinics from charging patients for insured health services.

In February 2007, a private clinic in Manitoba which had been charging patients for insured MRI services contracted with its Regional Health Authority to deliver these services until February 2010, thus resolving the issue for the duration of the contract.

As well, in March 2007, Nova Scotia confirmed that a physician had stopped charging patients as a condition of receiving insured services.

History of Deductions and Refunds Under the Canada Health Act

The *Canada Health Act*, which came into force April 1, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the Act provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244.732 million in deductions were refunded to New Brunswick ($6.886 million), Quebec ($14.032 million), Ontario ($106.656 million), Manitoba ($1.270 million), Saskatchewan ($2.107 million), Alberta ($29.032 million) and British Columbia ($84.749 million).

Following the *Canada Health Act*'s initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the Act did not reoccur until fiscal year 1994–1995. As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan.

This higher amount constituted extra-billing under the Act. Including deduction adjustments for prior years, dating back to fiscal year 1992–1993, deductions began in May 1994 until extra-billing by physicians was banned when changes to British Columbia's *Medicare Protection Act* came into effect in September 1995. In total, $2.025 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992–1993 and 1995–1996. These deductions and all subsequent deductions are non-refundable.

In January 1995, the federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the *Canada Health Act*. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

From November 1995 to June 1996, total deductions of $3.585 million were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of $284,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998. From November 1995 to December 1998, deductions from Manitoba's CHST cash contribution amounted to $2,055,000, ending with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001–2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of $50,033 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured services in fiscal years 1997–1998 and 1998–1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to $2,355,201.

With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Before it closed, a total deduction of $372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.

In January 2003, British Columbia provided a financial statement in accordance with the *Canada Health Act* Extra-billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000–2001, totalling $4,610. Accordingly, a deduction of $4,610 was made to the March 2003 CHST cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001–2002, in accordance with the requirements of the Extra-billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001–2002.

Deductions were taken from the March 2005 CHT payments to three provinces as a result of charges to patients which occurred during 2002–2003. A deduction of $72,464 was made to British Columbia on the basis of charges reported by the province for extra-billing and patient charges at surgical clinics. A deduction of $1,100 was made to Newfoundland and Labrador as a result of patient charges for a Magnetic Resonance Imaging scan in a hospital, and a deduction of $5,463 was made to Nova Scotia as a reconciliation for deductions that had already been made to Nova Scotia for patient charges at a private clinic.

Deductions were taken from the March 2006 CHT payments to British Columbia in respect of extra-billing and user charges at surgical clinics that occurred during fiscal year 2003–2004, in the amount of $29,019, on the basis of charges reported by the province to Health Canada.

A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT to reconcile amounts actually charged in respect of extra-billing and user charges at a private clinic with the penalties that had already been levied, based on provincial estimates reported for fiscal 2003–2004.

Deductions were taken from the March 2007 Canada Health Transfer (CHT) payments to British Columbia in respect of extra-billing and user charges at surgical clinics that occurred during fiscal year 2004–2005, in the amount of $114,850, on the basis of charges reported by the province to Health Canada.

Deductions were also taken from the March 2007 CHT payments to Nova Scotia in respect of extra-billing during fiscal year 2004–2005 in the amount of $9,460, on the basis of charges reported by the province to Health Canada.

Since the enactment of the *Canada Health Act*, from April 1984 to March 2007, deductions totaling $8,977,386 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the Act. This amount excludes deductions totalling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated.

CHAPTER 3

Provincial and Territorial Health Care Insurance Plans in 2006–2007

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the Canada Health Act program criteria and conditions in 2006–2007.

Officials in the provincial, territorial and federal governments have collaborated to produce the detailed plan overviews contained in Chapter 3. While all provinces and territories have submitted detailed descriptive information on their health insurance plans, Quebec chose not to submit supplemental statistical information which is contained in the tables in this year's report. The information that Health Canada requested from the territorial departments of health for the report consists of two components:

- a narrative description of the provincial or territorial health care system relating to the five criteria and the first condition (that of providing the Minister of Health with information in relation to insured health services and extended health care services) of the Act, which can be found following this chapter; and
- statistical information related to insured health services.

The narrative component is used to help with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the *Canada Health Act*, while statistics help to identify current and future trends in the Canadian health care system.

To help provinces and territories prepare their submissions to the annual report, Health Canada provided them with the document *Canada Health Act Annual Report 2006–2007: A Guide for Updating Submissions* (User's Guide). This guide was developed through discussion with provincial and territorial officials and is designed to help provinces and territories meet the reporting requirements of Health Canada. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for the *Canada Health Act Annual Report 2006–2007* was launched late spring 2007 with bilateral tele-conferences with each jurisdiction. An updated User's Guide was also sent to the provinces and territories at that time.

Insurance Plan Descriptions

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health insurance plan. The descriptions follow the program criteria areas of the *Canada Health Act* in order to illustrate how the plans satisfy these criteria.

This narrative description also includes information on how each jurisdiction met the *Canada Health Act* requirement for the recognition of federal contributions that support insured and extended health care services and a section outlining the range of extended health care services in their jurisdiction.

Provincial and Territorial Health Care Insurance Plan Statistics

In 2003–2004, the section of the annual report containing the statistical information submitted from the provinces and territories was simplified and streamlined following feedback received from provincial and territorial officials, and based on a review of data quality and availability. The format was further streamlined for the 2006–2007 report. The supplemental statistical information can be found at the end of each provincial or territorial narrative, except for Quebec.

The purpose of the statistical tables is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the federal Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental by province and territory for five consecutive years ending on March 31, 2007. All information was provided by provincial and territorial officials.

Although efforts are made to capture data on a consistent basis, differences exist in the reporting on health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions are not made. Provincial and territorial governments are responsible for the quality and completeness of the data they provide.

Organization of the Information

Information in the tables is grouped according to the nine subcategories described below.

Registered Persons: Registered persons are the number of residents registered with the health care insurance plans of each province or territory.

Insured Hospital Services within Own Province or Territory: Statistics in this sub-section relate to the provision of insured hospital services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Hospital Services Provided to Residents in Another Province or Territory: This sub-section presents out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada.

Insured Hospital Services Provided Outside Canada: Hospital services provided out of country represent residents' hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory.

Insured Physician Services Within Own Province or Territory: Statistics in this sub-section relate to the provision of insured physician services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Physician Services Provided to Residents in Another Province or Territory: This sub-section reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents.

Insure Physician Services Provided Outside Canada: Physician services provided out of country represent residents' medical costs incurred while travelling outside of Canada that are paid by their home province or territory.

Insured Surgical-Dental Services Within Own Province or Territory: The information in this subsection describes insured surgical-dental services provided in each province or territory.

Newfoundland and Labrador

Introduction

The majority of publicly funded health services in Newfoundland and Labrador are delivered through four regional health authorities. They focus on the full continuum of care including public health, community services, acute and long-term care services.

The provincial government appoints Boards of Trustees who serve as volunteers. These authorities are responsible for delivering health and community services to their regions, and in some cases, to the province as a whole. Regional authorities interact with the public and stakeholders to determine health needs. The regional authorities receive their funding from the provincial government, to which they are accountable. The Department of Health and Community Services provides the regional authorities with policy direction and monitors programs and services.

In Newfoundland and Labrador, almost 19,000 health care providers and administrators provide health services to 505,000 residents (based on 2006 census).

In May 2006, the Department announced a re-registration of the province's Medical Care Plan (MCP) to enhance the security for beneficiaries and tighten controls over the administration of the program. This measure will ensure that only eligible beneficiaries permanently residing in the province are able to avail themselves of coverage under the MCP. All residents of the province were required to complete a re-registration form in order to receive a new MCP card. Each new card will have an expiry date which will allow the government to effectively monitor MCP claims and ensure that only eligible residents of Newfoundland and Labrador are receiving services under the provincial plan. This is the first major overhaul of the program since it began in 1969.

Other key initiatives during the year included:

- A new *Pharmaceutical Services Act* was passed by the House of Assembly on December 12, 2006 and proclaimed in force on January 31, 2007. This new statute provides support for the Newfoundland and Labrador Prescription Drug Plan (NLPDP) and other associated programs.
- As part of the province's Poverty Reduction Strategy, the government extended eligibility for the Newfoundland and Labrador Prescription Drug Program (NLPDP) to more low-income residents. This initiative will increase the number of eligible residents by an estimated 85,000.
- Investments in health infrastructure included new projects for long-term care facilities in the Eastern, Western and Labrador/Grenfell regions. Construction has begun on a new addictions centre in the Western Region.
- HealthLine, the province's new telehealth service, was officially launched in September 2006, providing residents of the province with toll-free health information and advice 24 hours a day, seven days a week.
- Budget 2006 allocated $4.1 million for improvements to the Children's Dental Health Plan by significantly increasing the fees under the provincial fee schedule bringing them more in line with the levels of fees charged by dentists.
- Budget 2006 allocated $15.6 million as part of the new cancer control strategy for new cancer screening and treatment. This included $3.3 million for the construction of two bunkers to house radiation treatment machines, $2.2 for cervical and breast screening programs, and $10 million for new treatment therapies and medications.

- Medications for Alzheimer's Disease became eligible for the Newfoundland and Labrador Prescription Drug Program under special authorization in September 2006.

The Department continues to address the challenges of delivering quality health and community services to the people of the province while recognizing the challenges of an aging population, fiscal resource constraints, diverse geography and human resource issues.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and publicly administered.

The *Hospital Insurance Agreement Act* is the legislation that enables the Hospital Insurance Plan. The Act gives the Minister of Health and Community Services the authority to make Regulations for providing insured services on uniform terms and conditions to residents of the province under the conditions specified in the *Canada Health Act* and Regulations.

The *Medical Care Insurance Act* (1999) empowers the Minister to administer a plan of medical care insurance for residents of the province. It provides for the development of regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to administering the Medical Care Plan.

The Medical Care Plan facilitates the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures and systems that permit appropriate compensation to providers for rendering insured professional services. The Medical Care Plan operates in accordance with the provisions of the *Medical Care Insurance Act* (1999) and Regulations, and in compliance with the *Canada Health Act*.

There were no legislative amendments to the *Medical Care Insurance Act* (1999) or the *Hospital Insurance Agreement Act* in 2006–2007.

1.2 Reporting Relationship

The Department is mandated with administering the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes; e.g., Public Accounts and the Estimates Committee of the House of Assembly.

The Department will be tabling its 2006–2007 Annual Report in the House of Assembly in Fall 2007. The four regional health authorities and some health agencies will also table their reports.

The Department's Annual Report highlights the accomplishments of 2006–2007 and provides an overview of the initiatives and programs that will continue to be developed in 2007–2008. The report is a public document and is circulated to stakeholders. It will be posted on the department's website at:

www.health.gov.nl.ca/health

1.3 Audit of Accounts

Each year, the Province's Auditor General independently examines provincial public accounts. MCP expenditures are now considered a part of the public accounts. The Auditor General has full and unrestricted access to MCP records.

The four regional health authorities are subject to Financial Statement Audits, Reviews and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the health authorities under the terms of the *Public Tendering Act*. Review engagements, compliance audits and physician audits were carried out by personnel from the Department under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records and professional medical corporation records were reviewed to ensure that the records supported the services billed and that the services are insured under the MCP.

Beneficiary audits were performed by personnel from the Department under the *Medical Care Insurance Act* (1999). Individual providers are randomly selected on a bi-weekly basis for audit.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* and the Hospital Insurance Regulations 742/96 (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 36 facilities (14 hospitals and 22 community health centres) and 14 nursing stations. Insured services include: accommodations and meals at the standard ward level; nursing services; laboratory, radiology and other diagnostic procedures; drugs, biologicals and related preparations; medical and surgical supplies, operating room, case room and anaesthetic facilities; rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology); out-patient and emergency visits; and day surgery.

The coverage policy for insured hospital services is linked to the coverage policy for insured physician services. The Department of Health and Community Services manages the process of adding or de-listing a hospital service from the list of insured services based on direction from the Minister. There were no services added or de-listed in 2006–2007.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act* (1999).

Other governing legislation under the *Medical Care Insurance Act* includes:

- the Medical Care Insurance Insured Services Regulations;
- the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- the Medical Care Insurance Physician and Fees Regulations.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed by the College of Physicians and Surgeons of Newfoundland and Labrador to practice in the province. In 2006–2007, there were 985 physicians in the province.

An insured service is defined as one that is: listed in section 3 of the Medical Care Insurance Insured Services Regulations; medically necessary; and/or recommended by the Department of Health and Community Services. There are no limitations on the services covered, subject to these criteria.

For purposes of the Act, the following services are covered:

- all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and Regulations made under the Act.

Physicians can choose not to participate in the health care insurance plan as outlined in subsection 12(1) of the *Medical Care Insurance Act* (1999), namely:

(1) Where a physician providing insured services is not a participating physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

  (a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and

  (b) provide the beneficiary to whom the physician has provided the insured service with the information required by the minister to enable payment to be made under this Act to the beneficiary in respect of the insured service.

(2) Where a physician who is not a participating physician provides insured services through a professional medical corporation, the professional medical corporation is not, in relation to those services, subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services and the professional medical corporation and the physician providing the insured services shall comply with subsection (1).

As of March 31, 2007, there were no physicians who had opted out of the MCP.

Ministerial direction is required to add to or to de-insure a physician service from the list of insured services. This process is managed by the Department in consultation with various stakeholders, including the provincial medical association and the public. There were no services added or deleted during the 2006–2007 fiscal year to the list of insured physician services.

2.3 Insured Surgical-Dental Services

The provincial Surgical-Dental Program is a component of the Medical Care Plan (MCP). Surgical-dental treatments provided to a beneficiary and carried out in a hospital by a dentist are covered by MCP if the treatment is specified in the Surgical-Dental Services Schedule.

All dentists licensed to practice in Newfoundland and Labrador and who have hospital privileges are allowed to provide surgical-dental services. The dentist's license is issued by the Newfoundland Dental Board. In 2006–07, there were 27 dentists registered in the province.

Dentists may opt out of the Medical Care Plan. These dentists must advise the patient of their opted-out status, stating the fees expected, and provide the patient with a written record of services and fees charged.

Because the Surgical-Dental Program is a component of the MCP, management of the Program is linked to the MCP process regarding changes to the list of insured services.

Addition of a surgical-dental service to the list of insured services must be approved by the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by MCP include: preferred accommodation at the patient's request; cosmetic surgery and other services deemed to be medically unnecessary; ambulance or other patient transportation before admission or upon discharge; private duty nursing arranged by the patient; non-medically required x-rays or other services for employment or insurance purposes; drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital; bedside telephones, radios or television sets for personal, non-teaching use; fibreglass splints; services covered by the Workplace Health, Safety and Compensation commission or by other federal or provincial legislation; and services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the College of Physicians and Surgeons of Newfoundland and Labrador.

The use of the hospital setting for any services deemed not insured by the Medicare Plan are also uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care Insurance Act* (1999), the following is a list of non-insured physician services:

- any advice given by a physician to a beneficiary by telephone;
- the dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for, or on behalf of, or any communication to, or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosing the illness proposed to be treated by acupuncture;
- examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;
- plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma; circumcision of newborns; hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the province at a facility not approved by the College of Physicians and Surgeons of Newfoundland and Labrador;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- in vitro fertilization and OSST (ovarian stimulation and sperm transfer);
- reversal of previous sterilization procedure;
- surgical, diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the Hospitals Act or approved by the appropriate authority under paragraph 3(d); and
- other services not within the ambit of section 3 of the Act.

The majority of diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the province. Hospital policy concerning access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practice. Patients retain the right to financially upgrade the standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

Surgical-dental and other services not covered by the Surgical-Dental Program include the dentist's fee and the oral surgeon's or general practitioner's fees for routine dental extractions in a hospital.

3.0 Universality

3.1 Eligibility

Residents of Newfoundland and Labrador are eligible for coverage under the *Medical Care Insurance Act* (1999) and the *Hospital Insurance Agreement Act*. The *Medical Care Insurance Act* (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the province, but does not include tourists, transients or visitors to the province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations (Regulation 20/96) identify those residents eligible to receive coverage under the plans. MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications for coverage. MCP applies the standard that persons moving to Newfoundland and Labrador from another province become eligible on the first day of the third month following the month of their arrival.

Persons not eligible for coverage under the plans include: students and their dependants already covered by another province or territory; dependants of residents if covered by another province or territory; certified refugees and refugee claimants and their dependants; foreign workers with Employment Authorizations and their dependants who do not meet the established criteria; foreign students and their dependants; tourists, transients, visitors and their dependants; Canadian Forces and Royal Canadian Mounted Police (RCMP) personnel; inmates of federal prisons; and armed forces personnel from other countries who are stationed in the province.

3.2 Registration Requirements

Registration under the MCP and possession of a valid MCP card are required to access insured services. New residents are advised to apply for coverage as soon as possible on arriving in Newfoundland and Labrador. A re-registration of the province's MCP plan began in 2006. All residents of the province were required to complete a re-registration form in order to receive a new MCP card. The original deadline of March 3/07 was extended to July 31/07. Almost 450,000 residents (or 90% of the total population) had registered by March 31/07.

It is the parent's responsibility to register a newborn or adopted child. The parents of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from either parent's surname.

Applications for coverage of an adopted child require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the department. Applications for coverage of a child adopted outside Canada require Permanent Resident documents for the child.

3.3 Other Categories of Individual

Foreign workers, clergy and dependants of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Holders of Minister's permits are also eligible, subject to MCP approval. There are approximately 550 beneficiaries covered under a work permit, only 1 under a Minister's permit and approximately 5 dependents of NATO personnel. Clergy are included under the work permit or other category and numbers are not readily available.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage on the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Forces, the RCMP and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

Newfoundland and Labrador is a party to the Agreement on Eligibility and Portability regarding matters pertaining to portability of insured services in Canada.

Sections 12 and 13 of the Hospital Insurance Regulations (1996) define portability of hospital coverage during temporary absences both within and outside Canada. Portability of medical coverage during temporary absences both within and outside Canada is defined in Departmental policy.

The eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services, although there is no formalized process.

Coverage is provided to residents during temporary absences within Canada. The Government has entered into formal agreements (i.e. the Hospital Reciprocal Billing Agreement) with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient, high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans through the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

Except for Quebec, medical services incurred in all provinces or territories are paid through the Medical Reciprocal Billing Agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province at least four consecutive months in each 12-month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include the following:

- Before leaving the province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate.
- Beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months. Upon return, beneficiaries are required to reside in the province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months of coverage.

- Students leaving the province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located outside the province.
- Persons leaving the province for employment purposes may receive a certificate for coverage up to 12 months. Verification of employment may be required.
- Persons must not establish residence in another province, territory or country while maintaining coverage under the Newfoundland MCP.
- For out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request.
- For out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the province.

Failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

In 2006/2007, the total amount paid by MCP for physician services received by residents in another province or territory was $6,290,000.

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergencies, sudden illness and elective procedures at established rates. Hospital services are considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the Government's hospitalization plan for out-of-country in-patient hospital care is $350 per day, if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

The total amount spent by MCP in 2006/2007 for insured physician services provided outside Canada was $130,000.

Physician services are covered for emergencies or sudden illness and are also insured for elective services not available in the province or within Canada. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province where they are available.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories.

If a resident of the province has to seek specialized hospital care outside the country because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department. The referring physicians must contact the Department or the MCP for prior approval.

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the MCP so that patients may be made aware of any financial implications. General practitioners and specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for insured hospital services and no extra-billing by physicians in the province.

5.2 Access to Insured Hospital Services

In Newfoundland and Labrador there is a health care workforce of nearly 19,000 individuals. Half of this workforce belongs to regulated professional groups.

The supply of health professionals is a high-priority issue in the province, especially in rural areas.

In 2006–2007, the Department of Health and Community Services maintained its commitment to health human resource planning in the province. The Physician Resource Planning Committee was formed in March 2005 to develop a human resource plan for physicians and continued the work throughout the year. The Department participated in the Provincial Nursing Network, and formed a Diagnostics Workforce Network and an Allied Health Workforce Network to ensure system stakeholders have an opportunity to contribute to workforce planning. Networks have representation from employers, educators, unions, government, and professional associations.

In addition to the workforce networks, vice-presidents of human resources in regional health authorities met regularly and formed sub-committees with representation from their organizations and government. One sub-committee was formed for human resource planning in the Fall 2006 and has met several times to develop recommendations to address key workforce issues. Planning staff participated on several National expert working groups and committees as well as the Atlantic Advisory Committee on Health Human Resources. Several targeted initiatives addressed current and projected workforce issues, including the recruitment and retention of clinical pharmacists and diagnostics personnel, and projected needs for social work and nursing graduates.

The Department continued to offer recruitment incentives for physicians, registered nurses, audiologists, speech language pathologists, pharmacists, and other health professionals in 2006–2007.

Insured hospital services are provided by 36 hospitals and health centres across Newfoundland and Labrador. All facilities provide 24 hour emergency services, out-patient clinics, laboratory and x-ray services. The other services vary by facility and range from general surgery, internal medicine and obstetrics to specialized services such as cardiology and neurology. Quaternary care is not offered in Newfoundland and Labrador and provincial residents travel to other jurisdictions to access services.

Federal funding through the 2004 Health Accord enabled Newfoundland and Labrador to continue with investments to improve access to key services by purchasing new medical equipment, modernizing diagnostic and medical equipment and expanding select services in all of the province's major health care centres. The government has invested $28.6 million in the past two budget years to reduce wait times for select health services; purchase new equipment to increase capacity and support a new wait time management team.

Newfoundland and Labrador is making progress in reducing wait times for select health services. The province is already at, or near, the national benchmarks in the five priority areas identified in the 2004 Health Accord. The Department has begun planning for a patient wait time guarantee for cardiac surgery in order to access funding from the federal government. The guarantee will be implemented by March 2010.

In late 2005–2006, Newfoundland and Labrador announced a $14.5 million investment in a province-wide Picture Archiving and Communications System (PACS) by 2007. Steady progress in meeting project milestones in 2006/07 is being made with implementation planned for 2007/2008.

The provincial Primary Health Care (PHC) framework, "Moving Forward Together: Mobilizing Primary Health Care," is providing direction for remodelling primary health care in Newfoundland and Labrador through a population-health based approach to service delivery, and using a voluntary and incremental approach. PHC services include all the health services delivered in a geographic area (minimum population 6000 to maximum population of 25,000) from primary prevention through to, and including, acute and episodic illness at the PHC service delivery level.

The framework supports four goals: (1) enhanced access to, and sustainability of, primary health care; (2) an emphasis on self-reliant and healthy citizens and communities; (3) promotion of a team-based, interdisciplinary and evidenced-based approach to services provision; and (4) enhanced accountability and satisfaction of health professionals. Provincial supports have included a number of Departmental staff linkages with local college and university programs and professional associations, and developing provincial working groups to support learning/problem-solving and provider capacity-building.

Eleven interdisciplinary team-based PHC team areas have initiated changes to service delivery based on the provincial framework, including the development of Community Advisory Committees (CACs) and enhanced activities support health promotion and illness prevention. In addition, two PHC team areas have completed proposals and have been provided with funding for implementation, and two other areas have been provided funds for proposal development. Registration processes for PHC services have commenced in one of the PHC team areas. Formal evaluation of these changes was completed by external evaluators in the Fall of 2006 and a report is completed.

Primary health care working groups, with associations, university, PHC team area and other partnerships, have developed processes and tools for scope of practice shifts, physician funding and payment models and information management. Scope of practice processes have been implemented in the eight initial PHC team areas, with the development of action plans to assist in shifting scope of practices. This continues to be the practice for new sites.

A discussion document has been developed for physician funding and payment models, and a research project has been initiated at Memorial University regarding a funding and payment model. Physician networks are in development in the initial eight PHC team areas, and a physician network contract (for signing by the Department of Health & Community Services, the region, and the physician network for medical services to the PHC team area) is in the latter stages of completion.

In the spring of 2005, a Chronic Disease Prevention and Management (CDPM) Collaborative program, with diabetes as the first collaborative, was funded provincially on an operational basis, and initiated in 8 PHC team areas. These collaboratives will support CDPM from primary prevention through to management, and include provincial Learning Sessions to promote professional development regarding chronic diseases. In addition, a software application is being supported through Eastern Health Authority that will provide information regarding adherence to clinical practice guidelines, and also for service planning at the individual client, PHC team area, regional and provincial levels. Plans to move forward with collaboratives for mental health and arthritis are in the early stages.

Newfoundland and Labrador is currently involved in two Atlantic Canada projects. The Building a Better Tomorrow Initiative (BBTI) has been supporting team and inter-professional development and change management in PHC team areas through a variety of training modules (team development, conflict resolution, adult learning, understanding PHC, community development, and program planning and evaluation). In partnership with New Brunswick, a Memorandum of Understanding has been completed for a 24/7 toll-free health advice telephone service. Three sites are currently operational in this province: St. Anthony, Stephenville and Corner Brook.

5.3 Access to Insured Physician and Surgical-Dental Services

The number of physicians practicing in the province has been relatively stable, with an upward trend since 2003. The Department is committed to working with regional health authorities to develop a provincial human resource plan for physicians based on the principle of access to services.

As of March 31, 2007, there were 481 general practitioners and 504 specialists in practice, compared with 471 general practitioners and 500 specialists as of March 31, 2006. This represents a two percent increase in general practitioners and a one percent increase in specialists.

The Department has several measures to ensure access for insured physician services. Some of these include:

- funding for the Provincial Office of Recruitment;
- retention bonuses for salaried physicians based on geography and years of service; and
- an annual bursary program valued at $1.2 million for medical residents and students (matched to FP in CARMS) willing to commit to provide medical services in areas of need within the province. During fiscal year 2006–2007, 37 bursaries and travelling fellowships were funded.

5.4 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act* (1999).

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract and sessional block funding.

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), on behalf of all physicians. Representatives from the regional health authorities play a significant role in this process. In 2005, a four-year agreement was negotiated with the provincial medical association effective October 1, 2005.

5.5 Payments to Hospitals

The Department is responsible for funding regional health authorities for ongoing operations and capital acquisitions. Funding for insured services is provided to the regional health authorities as an annual global budget. Payments are made in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act*. As part of their accountability to the Government, the health authorities are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility and accountability to all appointed boards in the discharge of their mandates.

Throughout the fiscal year, the regional health authorities forwarded additional funding requests to the Department for any changes in program areas or increased workload volume. These requests were reviewed and, when approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for additional approved positions or program changes, were funded based on the implementation date of such increases and the cash flow requirements.

Regional health authorities are continually facing challenges in addressing increased demands when costs are rising, staff workloads are increasing, patient expectations are higher and new technology is introducing new demands for time, resources and funding. Regional health authorities continue to work with the Department to address these issues and provide effective, efficient and quality health services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) has been recognized and reported by the Government of Newfoundland and Labrador in the annual provincial budget, through press releases, government websites and various other documents. For fiscal year 2006–2007, these documents included:

- the 2006–2007 Public Accounts;
- the Estimates 2006–2007; and
- the Budget Speech 2006.

The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available to Newfoundland and Labrador residents and have been shared with Health Canada for information purposes.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community-based programs for persons discharged from hospital, seniors, and persons with disabilities. These programs are provided by the regional health authorities. Services include the following:

- Long-term residential accommodations are provided for residents requiring high levels of nursing care in 22 community health centres 19 nursing homes, a psychiatric facility, and a rehabilitation facility. There are approximately 2,730 beds located in these facilities. Residents pay a maximum of $2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department.
- Persons requiring supervised care or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 3,637 beds located in 105 homes across the province. These homes are operated by the private for-profit sector. Residents are subsidized to a maximum of $1,500 per month, based on an individual client assessment using standardized financial criteria.
- Home Care Services including professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed by the four regional health authorities. Non-professional services include personal care, household management, respite and behavioural management. These services are delivered by home support workers through

agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial criteria. The monthly ceiling for home support services in fiscal 2006–2007 was $2,707 for seniors and $3,875 for persons with disabilities.

- The Air Ambulance Program provides air transport for patients requiring emergency care who could not be transported by a commercial airline or by road ambulance because of urgency or time, or remoteness of location. This program uses two fixed-wing aircraft and five chartered helicopters. These helicopters are also used for routine transportation of doctors and nurses to remote communities for clinics. A third fixed-wing aircraft is used in Labrador for regional medical services transports, including routine appointments by coastal residents in Happy Valley/Goose Bay, Labrador.
- Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the province, may qualify for financial assistance under the Medical Transportation Assistance Program. This program is administered by the Department. Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance, as administered by Eastern Health, when the recipient is a Newfoundland and Labrador resident eligible for coverage under the provincial Hospital Insurance and Medical Care Plans.
- The Dental Health Plan incorporates a children's dental component and an Income Support component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at six-month intervals; cleanings at 12-month intervals; fluoride applications at 12-month intervals for children aged 6 to 12; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. Services are available to recipients of Income Support who are 13 to 17 years of age: examinations (every 24 months); x-rays (with some limitations); routine fillings and extractions; emergency extractions, when the patient is seen for pain, infection or trauma. Adults receiving income support are eligible for emergency care and extractions.
- The Newfoundland and Labrador Prescription Drug Program (NLPDP) provides prescription drugs and additional drug benefits approved by the Department of Health and Community Services which are listed in the Newfoundland and Labrador Prescription Drug Program Benefit List. These approved benefits are supplied as part of the Income Support, Senior Citizens, Special Needs and Low Income Drug Components for eligible residents.
- The Income Support Component provides prescription drug coverage for residents of the province who qualify for full benefit coverage under the Department of Human Resources, Labour and Employment. Coverage is also provided for residents who, due to the high cost of their medications, may qualify for drug card only benefits, residents in Government subsidized Long Term Care Facilities, children in care, and youth corrections. The Income Support Component covers the full cost of benefit prescription items, including a set mark-up amount and dispensing fee.
    - The Senior Citizens Component provides prescription drug coverage for residents who are 65 years of age or over, who are in receipt of the federal Guaranteed Income Supplement (GIS) and who are registered for the Old Age Security (OAS) benefits. The Senior Citizens Component covers defined ingredient cost only for identified benefits. Any additional cost, such as dispensing fees, is the client's responsibility.

- Ostomy Subsidy benefits are available to those senior citizens who qualify for a drug card under the Senior Citizens' Drug Subsidy or the Income Support Components. Government will reimburse eligible senior citizens for 75% of the retail cost of items that are benefits. Eligible seniors are responsible for the remaining costs.
- The Special Needs Component provides universal coverage for patients with Cystic Fibrosis and Growth Hormone Deficiency. The Special Needs Component covers the full cost for identified benefits — disease-related prescription drugs, enzymes, foods, medical supplies, and equipment — supplied through the Health Sciences Central Supply and Pharmacy.
- The Low Income Drug Component provides prescription drug coverage for residents of Newfoundland and Labrador who are eligible for and in receipt of a MCP card and who fall within specific income thresholds. The Low Income Drug Component covers a percentage of drug costs (ranging from 30–80%) dependant upon family income.

- The Government of Newfoundland and Labrador recently approved legislation governing the Newfoundland and Labrador Prescription Drug Program. The *Pharmaceutical Services Act* which came into effect on January 31, 2007 states that the NLPDP will be the payer of last resort. This means that if a patient has private insurance, they are required to bill their private insurance first.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	560,644	599,907	569,835	545,160	545,629 [1]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	36	36	36	36	36
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	36	36	36	36	36
3. Payments for insured health services ($):					
a. acute care	666,472,833	666,773,382	679,024,717	740,235,437	743,680,905
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	666,472,833 [2]	666,773,382 [2]	670,024,717 [2]	740,235,437 [2]	743,680,905 [2]
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	286,425	280,250	264,575	285,475	288,800
b. diagnostic imaging facilities	0	0	0	0	0
c. total	286,425	280,250	264,575	285,475	288,800

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
6. Total number of claims, in-patient (#).	1,588	1,640	1,699	1,809	1,736
7. Total payments, in-patient ($).	10,817,595	12,397,072	12,248,758	15,130,363	15,157,341
8. Total number of claims, out-patient (#).	26,464	25,762	26,467	29,628	34,349
9. Total payments, out-patient ($).	3,488,186	3,232,235	4,321,173	5,132,112	6,755,412
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	61	62	50	54	60
11. Total payments, in-patient ($).	269,963	363,153	76,981	112,039	92,683
12. Total number of claims, out-patient (#).	278	283	301	261	345
13. Total payments, out-patient ($).	18,432	167,588	60,159	24,265	934,295 [3]

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1. Newfoundland and Labrador is in the process of re-registering residents and issuing new cards with expiry dates, to ensure that only permanent residents are eligible for health care services under the provincial plan. The 2006–2007 number represents re-registered residents plus individuals currently holding valid cards who have yet to re-register.

2. New Methodology for 2002–2003. Operating costs only; does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services

3. Increase attributable to patients who were granted prior approval to receive insured services outside the country.

Insured Physician Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#): [4]					
a. general practitioners	437	451	460	471	481
b. specialists	477	499	494	500	504
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	914	950	954	971	985
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	not available	not available	not available	not available	not available
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	4,353,000	3,953,889	4,019,000	4,234,000	4,295,000
b. total payments ($)	129,118,000	153,352,000	175,910,000	180,263,000	182,730,000

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	116,000	139,000	113,000	136,000	139,000
20. Total payments ($).	4,231,000	4,518,000	4,770,000	5,197,000	6,290,000
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	2,400	1,800	2,400	2,300	2,100
22. Total payments ($).	172,000	199,000	136,000	135,000	130,000

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	33	25	31	26	27
24. Number of services provided (#).[5]	3,522	3,609	3,022	2,633	2,044
25. Total payments ($).	419,000	462,000	329,000	313,000	123,000

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4. Excludes inactive physicians. Total Salaried and Fee-for-service.

Prince Edward Island

Introduction

The Ministry of Health is a system of integrated services whose aim is to protect, maintain and improve the health and well-being of Prince Edward Islanders. Health services in Prince Edward Island are delivered under a centralized management model.

The ministry is responsible for a variety of health services to Islanders to promote and help foster their optimal health, including public health services, primary care, acute care, community hospital and continuing care services. These services are delivered by over 4,500 dedicated professional staff through a large number of facilities and programs across the province. Included are:

- acute care facilities;
- community hospitals;
- provincial manors;
- an in-patient mental health facility;
- a provincial addictions treatment facility and community programs;
- family health centres;
- public health, home care, community addictions programs;
- community mental health;
- the Chief Health Officer; and
- Vital Statistics and regulatory services.

Under the *Health and Community Services Reorganisation Act (2006)* and the *Community Hospitals Reorganisation Act (2006)* all health regions were dissolved and the general administration of health services was brought under the authority of the Department of Health and Community Hospital Authorities were established to manage the rural hospitals.

A Minister of the Crown is ultimately accountable to the rest of government and the citizens of PEI for the Department of Health and its performance and results. The Department is managed by a Departmental Management Committee comprised of the Deputy Minister and eight senior directors whose responsibility it is to direct the overall departmental management and day-to-day operations. A summary of the principal roles of division is outlined below.

Acute Care: Provides regional and provincial secondary, specialty services, and in-patient mental health services to residents of PEI. Facilities include Prince County Hospital (PCH), the Queen Elizabeth Hospital (QEH) and Hillsborough Hospital. Administratively, one Executive Director is responsible for PCH and one Executive Director is responsible for QEH / Hillsborough Hospital, both of whom are members of the Departmental Management Committee.

Community Hospitals and Continuing Care: Provides acute care services to rural communities and supportive services to adults and seniors in need of continuing care on PEI. Programs and facilities include the five rural community hospitals, provincial manors, home care, palliative care, dialysis, and adult protection. Administratively, the Director of Community Hospitals and Continuing Care is responsible for this division and is a member of the Departmental Management Committee.

For each of the five community hospitals, a governing board has been put in place. Each board is accountable to the Minister, and is responsible for ensuring the completion of annual business plans and reporting on facility performance and results to the Minister and their local communities.

Primary Care: Provides primary health services to citizens of PEI. Programs and facilities include: Community Mental Health and Addictions including the Provincial Addictions Treatment Facility, seven Family Health Centres, Public Health Nursing, and Chronic Disease Prevention. Administratively, the Director of Primary Care is responsible for this division and is a member of the Departmental Management Committee

Population Health: Provides Public Health and Regulatory Services to the citizens of PEI. Programs and services include the Office of Chief Health Officer, Emergency Health Services, Communicable Disease Control and Immunization, Epidemiology, Environmental Health, Vital Statistics, Community Care / Nursing Home Inspection, and Dietic Services. Administratively, the Director of Population Health is responsible for this division and is a member of the Departmental Management Committee.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan, under the authority of the Minister of Health, is the vehicle for delivering hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988), which insures services as defined under section 2 of the *Canada Health Act.*

The role of the Department is to provide sound leadership in innovation and ongoing improvement, quality administration and regulatory services, and delivery of client-centred health services, consistent with community needs.

The Department of Health is responsible for service delivery and operates hospitals, health centres, manors and mental health facilities. The Public Service Commission hires physicians, nurses and other health related workers.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister responsible who tables it in the Legislative Assembly. The Report provides information on the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions and statistical highlights for the year.

The community hospital authority boards are accountable to the Minister pursuant to the *Community Hospital Authorities Act* and must submit annual business plans and provide information to the Minister as and when required.

1.3 Audit of Accounts

The provincial Auditor General conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department of Health.

The provincial Auditor General, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program specific basis. Community hospital authorities are reporting entities under the *Financial Administration Act.*

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include: necessary nursing services; laboratory; radiological and other diagnostic procedures; accommodations and meals at a standard ward rate; formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital; operating room, case room and anaesthetic facilities; routine surgical supplies; and radiotherapy and physiotherapy services performed in hospital.

The process to add a new hospital service to the list of insured services involves extensive consultation and negotiation between the Department and key stakeholders. A business plan would be developed which when approved by the Minister would be taken to Treasury Board for funding approval. The Cabinet has the final authority in adding new services.

As of March 2007, there were seven acute care facilities participating in the province's insurance plan. In addition to 427 acute care beds, these facilities house 20 rehabilitative beds and 20 day surgery beds, as defined under the *Hospitals Act* (1988), for a total of 467 beds.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988). Amendments were passed in 1996. Changes were made to include the physician resource planning process.

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The total number of practitioners who billed the Insurance Plan as of March 31, 2007, was 314.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health.

Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside the Plan or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2007, no physicians had opted out of the Health Care Insurance Plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include most physicians' services in the office, at the hospital or in the patient's home; medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary; obstetrical services, including pre- and post-natal care, newborn care or any complications of pregnancy such as miscarriage or Caesarean section; certain oral surgery procedures performed by an oral surgeon when it is medically required, with prior approval that they be performed in a hospital; sterilization procedures, both female and male; treatment of fractures and dislocations; and certain insured specialist services, when properly referred by an attending physician.

The process to add a physician service to the list of insured services involves negotiation between the Department and the Medical Society. A business plan would be developed which when approved by the Minister would be taken to Treasury Board for funding approval. Cabinet has the final authority in adding new services.

2.3 Insured Surgical-Dental Services

Dental services are not insured in the Health Care Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital or in an office with prior approval as confirmed by the attending physician.

A surgical-dental service (post-operative removal of mandibular wires in an office setting) has been added as a result of negotiations between the Dental Association and the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include:

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by the Department;
- advice or prescriptions by telephone, except anticoagulant therapy supervision;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from the Department;
- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- testimony in court;
- travel clinic and expenses;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
- reversal of sterilization procedures;
- in vitro fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and
- any other services that the Department may, upon the recommendation of the negotiation process between the Department and the Medical Society, declare non-insured.

Provincial hospital services not covered by the Hospital Services Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of the Department.

The process to de-insure services by the Health Care Insurance Plan is done in collaboration with the Medical Society and the Department. No services were de-insured during the 2006/2007 fiscal year.

All Island residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Board of Prince Edward Island do not receive priority access to services through additional payment.

Prince Edward Island has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Department to monitor usage and service concerns.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations, section 3, define eligibility for the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day, in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Forces, Royal Canadian Mounted Police (RCMP), inmates of federal penitentiaries and those eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in certain circumstances. Members of the Canadian Forces or RCMP become eligible on discharge or completion of rehabilitative leave. Penitentiary inmates become eligible upon release. In such cases, the province where the individual in question was stationed at the time of discharge or release, or release from rehabilitative leave, would provide initial coverage during the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

Foreign students, tourists, transients or visitors to Prince Edward Island do not qualify as residents of the province and are, therefore, not eligible for hospital and medical insurance benefits.

3.2 Registration Requirements

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks before renewal.

The number of residents registered for the Health Care Insurance Plan in Prince Edward Island as of March 31, 2007, was 145,047.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province, as allowed under section 5.(1)(e) of the *Health Services Payment Act.*

The term "temporarily absent" is defined as a period of absence from the province for up to 182 days in a 12 month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the province under the above circumstances must notify the Registration Department before leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement. The total amount paid under these agreements in 2006/2007 was $25,850,500.

The payment rate currently ranges from $748 at the community hospitals to $755 at Prince County Hospital and $959 at the Queen Elizabeth Hospital per day for hospital stays. The standard interprovincial outpatient rate is $164. The methodology used to derive these rates is as if the patient had the services provided in Prince Edward Island.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act.*

Insured residents may be temporarily out of the country for a 12 month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For Island residents travelling outside Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department. In 2006–2007, the total amounts paid for in-patient claims was $105,268 and $16,179 for out-patient claims.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency, out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a Prince Edward Island physician. Full coverage may be provided for (Prince Edward Island insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act.*

Prince Edward Island has two referral hospitals and five community hospitals, with a combined total of 463 beds. Along with nine government manors (and facilities) that house 558 (plus 10 respite) long-term care nursing beds, Islanders have access to an additional 389 (plus 11 temporary beds) in nine private nursing homes. The system also operates several addictions and mental health facilities, including the provincial in-patient psychiatric Hillsborough Hospital which has 18 acute care beds and 57 long term care beds.

A $50 million health facility, the Prince County Hospital, was opened in April 2004 in Summerside. Phase I of a $52 million multi-phase redevelopment plan to upgrade the 24-year-old Queen Elizabeth Hospital is underway and construction is expected to begin in early 2008. This redevelopment will ultimately result in the major redesign of the emergency department and enhancements to ambulatory care among other improvements.

The public sector health workforce has approximately 4,500 employees. There is ongoing recruitment to address vacancies in the physician complement in this province. This challenge is being met in part by developing a long-term physician resource plan, by providing salary options to new graduates and existing physicians, and by engaging in more communication with PEI students and medical residents through the Medical Education Program.

Prince Edward Island is researching the viability of putting in place a Medical Residency Program to better integrate our medical students so that they will want to stay in the province.

In addition to the aforementioned programs, other current initiatives include:

- nurse Recruitment Strategy;
- provider Registry;
- musco-skeletal Injury Prevention Program (Workplace safety);
- wait Times Strategy;
- youth Addictions Strategy;
- clinical Information System interoperable Electronic Health Record;
- patient Safety Strategy; and
- pandemic Planning.

In the Provincial Budget for 2006–2007 the Government announced the reinstatement of the Registered Nurse Recruitment and Retention Strategy. Thirty-two BN students received sponsorships while in their final year of study.

Research indicates that our population is aging and exhibiting a variety of modifiable risk factors relating to physical inactivity, unhealthy eating, alcohol consumption, smoking and obesity. As in previous years, the rate of chronic diseases continues to rise. As the population ages, so too will the number of people affected by chronic disease. A variety of initiatives are in place which directly or indirectly address current and future levels of chronic disease. Examples include primary care redesign, which included establishment of family health centres; innovations and improvements in the areas of pharmacare, home care, and wait times being developed and implemented; and the Clinical Information System /Electronic Health Record to improve health care provider access to timely and accurate information. This will improve the overall quality of care and health outcomes for patients. Furthermore, models of service delivery and health care provider roles continue to evolve. Increased adoption of collaborative/inter-disciplinary approaches as well as enhancements in the areas of ambulatory care (including the multi-year QEH Redevelopment project) and primary health care will contribute to chronic disease prevention, treatment, and management.

Collaborative strategies focussed on promoting healthier lifestyles include:

- the Cancer Control Strategy, which includes a partnership with the PEI Cancer Control Committee, which works to reduce the burden of cancer on PEI by identifying priorities, coordinating efforts, monitoring progress and communicating results from the strategy;
- the PEI Strategy for Healthy Living, which focuses on tobacco reduction and promoting exercise and good nutrition; and the

- PEI Active Living Alliance, which promotes physical activity through a variety of community activities.

As PEI is primarily a rural province where a large segment of the population resides outside the main service centres, local access to health services, including acute services delivered through community hospitals, is important to small communities. Rural hospitals have historically played an important role in health care delivery and serve vital and central roles in their respective communities. Rural hospitals and other health services delivered in these areas face a number of challenges, such as the recruitment and retention of health care providers and keeping pace with evolving standards of care and quality. To help assist recruitment efforts and stabilize physician services in rural emergency rooms the Rural Physician Stabilization Initiative was announced. This initiative established a new daily on-call fee structure for physicians providing emergency on-call services in rural hospitals. This has continued to be a focus for our health system.

5.3 Access to Insured Physician and Surgical-Dental Services

Physician services are accessible throughout the province except for specialties where there are vacancies. Recruitment processes have been undertaken for family physicians, anaesthetists, radiologists, radiation and medical oncologists, psychiatrists, and a pathologist and plastic surgeon.

An enhanced Physician Recruitment/Retention and Medical Education *Strategy* was announced to build on existing initiatives and address the financial, professional, and lifestyle concerns of today's physicians. These enhancements are targeted towards physicians in training, physicians being recruited to Prince Edward Island, and physicians currently in practice on PEI.

As of March 31, 2007 there were the following vacancies in the physician complement: Family Medicine, Internal Medicine, Emergency Medicine, Psychiatry, Radiology, Pathology, Hospitalists, Ophthalmology and Plastic Surgery, overall totalling 16 vacancies. Recruitment to find suitable placements for these positions is ongoing.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and the government to represent their interests in the process. The Physician Master Agreement expired March 31, 2007. A negotiation team has been appointed and one meeting was held in January, 2007. The government continues to make additional investments to address areas that will make the health system more competitive so that it can maintain services and increase the success of recruitment and retention efforts for physicians.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Many physicians continue to work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are growing and seem to be the preference for new graduates. Currently almost 50 percent of physicians are compensated under salary or sessional payments.

5.5 Payments to Hospitals

The community hospital authorities are responsible for delivering hospital services in the province under the Community *Hospital Authorities Act*. The financial (budgetary) requirements are established annually through annual business plans approved by the Minister and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to provincial hospitals and the community hospital authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The usual funding method includes using a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health Transfer in its 2006–2007 Annual Budget and related budget documents and its 2005–2006 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not insured services, except for the insured chronic care beds noted in section 2.1.

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

Nursing home services are available on approval from regional admission and placement committees for placement into public manors and licensed private nursing homes. There are currently 18 long-term care facilities in the province, nine public manors and nine licensed private nursing homes, with a total of 968 beds, including respite and temporary beds. Nursing home admission is for individuals who require 24 hour registered nurse (nursing care) supervision and care management. The standardized Seniors Assessment Screening Tool is used to determine service needs of residents for all admissions to nursing homes.

Significant changes were made to long-term nursing care funding and subsidization in Janurary, 2007. First, self-paying residents in nursing homes are no longer required to cover the health care portion of their cost and are only required to cover their accommodation cost. Secondly, eligibility for subsidization was changed to be based on an assessment of income rather than on the applicant's total financial resources which previously included income and assets. When a resident of a facility or someone coming into a facility does not have the financial resources to pay for their own care, they can apply for financial assistance under the Social Assistance Act Regulations, Part II. The Province subsidizes 72 percent of residents in nursing homes. The federal government subsidizes approximately 8.7 percent of nursing home residents through Veterans Affairs Canada. The remaining 18.4 percent finance their own care.

In addition to nursing home facilities, there are 38 licensed community care facilities in Prince Edward Island. As of March 31, 2007, the total number of licensed community care facility beds was 938. A Community Care Facility is a privately operated, licensed establishment with five or more residents. These facilities provide semi-dependent seniors and semi-dependent physically and mentally challenged adults with accommodation, housekeeping, supervision of daily living activities, meals and personal care assistance for grooming and hygiene. Care needs are assessed using the Seniors Assessment Screening Tool and are at Level 1, 2 or 3. Residents are eligible to apply for financial assistance under the Social Assistance Act Regulations, Part I. It should be noted that payment to community care is the responsibility of the individual. Clients lacking adequate financial resources may apply for financial assistance under the *Prince Edward Island Social Assistance Act.*

7.2 Home Care Services

Home Care and Support provides assessment and care planning to medically stable individuals, and defined groups of individuals with specialized needs, who, without the support of the formal system, are at risk of being unable to stay in their own home, or are unable to return to their own home from a hospital or other care setting. Services provided through Home Care and Support include nursing, personal care, respite, occupational and physical therapies, adult protection, palliative care, home and community-based dialysis, assessment for nursing home placement and community support. The Senior's Assessment Screening Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment, which is generally waived for palliative care clients.

7.3 Ambulatory Health Care Services

Prince Edward Island has public Adult Day Programs that provide services such as recreation, education and socialization for dependent elders. Individuals who require this service are assessed by regional Home Care staff. The overall purpose of adult day programs, is to allow clients to remain in their homes as long as possible, provide respite for care givers, monitor client's health and provide social interaction. There are Adult Day Programs located across Prince Edward Island.

The Prince Edward Island Dialysis Program is a community-based service that operates under the medical direction and supervision of the Nephrology team at the Queen Elizabeth II Health Sciences Centre in Halifax.

There are five hemo-dialysis clinics in the province. This is a publicly funded service. Prince Edward Island also offers a hemo-dialysis service to out-of-province/country visitors from the existing clinic locations. The provision of this service is based on the capacity within the clinics and the availability of human resources to provide this treatment at the time of the request. Cost of the service is covered through reciprocal billing if from another Canadian jurisdiction and by the visitor if from out of Canada.

Significant ambulatory care services are also delivered from the two provincial referral hospitals on an out-patient basis. These services include asthma education, cardio-pulmonary testing and treatment, endoscopy, surgery clinics, nursing clinics, nutrition counselling and oncology.

Registered Persons	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	141,031	142,022	143,261	144,159	145,047

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	7	7	7	7	7
b. chronic care	not applicable	not applicable	not applicable	not applicable	not appliciable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not appliciable
d. other	not applicable	not applicable	not applicable	not applicable	not appliciable
e. total	7	7	7	7	7
3. Payments for insured health services ($):					
a. acute care	115,697,000	121,944,000	125,118,252	129,976,900	137,365,100
b. chronic care	not applicable	not applicable	not applicable	not applicable	not appliciable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not appliciable
d. other	not applicable	not applicable	not applicable	not applicable	not appliciable
e. total	115,697,000	121,944,000	125,118,252	129,976,900 [1]	137,365,100 [1]
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
6. Total number of claims, in-patient (#).	2,059	2,006	2,163	2,187	2,003
7. Total payments, in-patient ($).	11,713,751	14,208,471	15,325,267	16,463,548	17,510,188
8. Total number of claims, out-patient (#).	16,790	15,638	14,368	15,547	15,675
9. Total payments, out-patient ($).	2,879,064	2,578,895	2,667,968	3,225,803	3,345,624
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	23	37	30	25	35
11. Total payments, in-patient ($).	79,577	155,922	95,719	69,391	105,268
12. Total number of claims, out-patient (#).	152	130	93	91	96
13. Total payments, out-patient ($).	25,954	24,366	16,304	17,084	16,179

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1. Figures are budget estimates, not actuals.

Insured Physician Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	97	96	98	113	120
b. specialists	92	94	96	98	108
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	189	190	194	211	228 [2]
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	0
b. specialists	not applicable	not applicable	not applicable	not applicable	0
c. other	not applicable	not applicable	not applicable	not applicable	0
d. total	not applicable	not applicable	not applicable	not applicable	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	1,264,991	1,330,946	2,504,320	1,387,070	9,795,812 [3]
b. number of records					1,312,506 [4]
b. total payments ($)	36,475,710	36,732,119	40,012,026	40,027,386	41,778,719 [5]
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	1,079,216	1,161,548	1,197,935	1,052,167	937,707
b. number of records					794,706
b. total payments ($)	32,984,220	33,289,335	34,423,393	35,226,215	34,543,095

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#). Number of Records	48,369	45,255	48,928	54,269	73,399 58,284
20. Total payments ($).	3,778,171	3,795,244	4,122,725	4,674,004	5,221,586
Insured Physician Services Provided Outside Canada					
21. Number of services (#). Number of Records	521	706	627	534	746 681
22. Total payments ($).	30,076	37,100	21,849	15,844	27,899

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	2	2	2	3	3
24. Number of services provided (#). Number of records provided	312	393	410	303	442 332
25. Total payments ($).	88,443	90,851	96,490	115,918	106,708

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[2] Total does not include locums.

[3] Beginning in 2006–2007 Service count reflects the total # of transactions recorded within all records. The service count will always be greater than or equal to the record count.

[4] Beginning in 2006-2007 Record count reflects total # of individual interactions with insured health services.

[5] Reflects payments made through claim submissions.

Nova Scotia

Introduction

The Nova Scotia Department of Health's mission is through leadership and collaboration to ensure an appropriate, effective and sustainable health system that promotes, maintains and improves the health of Nova Scotians. This requires that health care services in Nova Scotia are integrated, community-based and sustainable.

In February 2006, the Government of Nova Scotia created a new Department of Health Promotion and Protection that brought together two areas from the Department of Health, the Office of the Chief Medical Officer of Health and Public Health branch, with Nova Scotia Health Promotion.

The *Health Authorities Act*, Chapter 6 of the Acts of 2000, established the province's nine District Health Authorities (DHAs) and their community-based supports, Community Health Boards (CHBs). DHAs are responsible for governing, planning, managing, delivering and monitoring health services within each district and for providing planning support to the CHBs. Services delivered by the DHAs include acute and tertiary care, mental health, and addictions.

The province's thirty-seven CHBs develop community health plans with primary health care and health promotion as their foundation. DHAs draw two thirds of their board nominations from CHBs. Their community health plans are part of the DHAs annual business planning process. In addition to the nine DHAs, the IWK Health Centre continues to have separate board, administrative and service delivery structures.

The Department of Health is responsible for setting the strategic direction and standards for health services, ensuring availability of quality health care, monitoring, evaluating and reporting on performance and outcomes and funding health services. The Department of Health is directly responsible for physician and pharmaceutical services, emergency health, continuing care, and many other insured and publicly funded health programs and services.

Under the *Health Authorities Act*, the DHAs are required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. They are also required to submit annual reports, which provide updates on implementing DHA business plans. These provisions ensure greater financial accountability. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

Pursuant to the *Provincial Finance Act* (2000) and government policies and guidelines, the Department of Health is required to release annual accountability reports outlining outcomes against its business plan for that fiscal year. The 2006–2007 accountability report will be available in late 2007.

Nova Scotia faces a number of challenges in the delivery of health care services. Nova Scotia's population is aging. Approximately 14.1% of the Nova Scotian population is sixty-five or over and this figure is expected to nearly double by 2026. In response to the needs of our aging population, Nova Scotia has expanded its basket of publicly insured services to include home care long-term care, and enhanced pharmaceutical coverage. Nova Scotia also has much higher than average rates of chronic diseases such as cancers and diabetes which contribute to the rising costs of health care delivery in Nova Scotia.

Other major cost drivers are a highly competitive labour market for health human resources, the increasing costs of pharmaceuticals and aging facility infrastructure.

Despite these ever increasing pressures and challenges, Nova Scotia continues to be committed to the delivery of medically necessary services consistent with the principles of the *Canada Health Act.*

Additional information related to health care in Nova Scotia may be obtained from the Department of Health website at:

www.gov.ns.ca/health

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Insurance Plan (HSI) and the Medical Services Insurance Plan (MSI). The Department of Health administers the HSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35.

The MSI is administered and operated by an authority consisting of the Department of Health and Medavie Blue Cross (formerly called Atlantic Blue Cross), under the above-mentioned Act (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32 and 35).

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the Regulations, all residents of the province are entitled to receive insured hospital services from hospitals on uniform terms and conditions. As well, all residents of the province are insured on uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to enter into agreements and vary, amend or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

The Department of Health and Medavie Blue Cross entered into a new service level agreement, effective August 1, 2005. This new ten-year agreement replaced the 1992 Memorandum of Agreement between Medavie and the Department of Health. Under the agreement, Medavie is responsible for operating and administering programs contained under MSI, Pharmacare Programs and Health Card Registration Services.

1.2 Reporting Relationship

Medavie is obliged to provide reports to the Department under various Statement of Requirements for each Business Service Description as listed in the contract.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the Hospital Insurance Regulations, under this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health.

1.3 Audit of Accounts

The Auditor General's office audits all expenditures of the Department of Health. A contract is in place to have an annual audit performed on the Insured Prescription Drug Plan Trust Fund. The Department of Health has a service level agreement in place with Medavie Blue Cross, effective August 1, 2005. An audit plan is under development for this agreement, including Medicare payments, which has been recommended by the Auditor General's office.

All long-term care facilities, home care and home support agencies are required to provide the Department with annual audited financial statements.

Under section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health by July 1st each year, an audited financial statement for the preceding fiscal year.

The June, 2006 Report of the Auditor General of Nova Scotia contained audits with respect to:

- District Health Authorities — Colchester East Hants and Cumberland & Pictou County
- Payments to Physicians

The December 2006 Report of the Auditor General of Nova Scotia contained audits with respect to collection of wait time information.

1.4 Designated Agency

Medavie Blue Cross Care administers and has the authority to receive monies to pay physician accounts under a new service level agreement with the Department of Health, effective August 1, 2005. Medavie Blue Cross Care receives written authorization from the Department for the physicians to whom it may make payments. The rates of pay and specific amounts depend on the physician contract negotiated between Doctors Nova Scotia and the Department of Health.

All Medavie Blue Cross Care system development for MSI and Pharmacare is controlled through a joint committee. All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Nine District Health Authorities and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in- and out-patients in Nova Scotia in a total of 35 facilities.[1]

Accreditation is not mandatory, but all facilities are accredited at a facility or district level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made pursuant to the *Health Services and Insurance Act*.

In-patient services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations, when administered in a hospital;
- routine surgical supplies;
- use of operating room, case room and anaesthetic facilities;
- use of radiotherapy and physiotherapy services, where available; and
- blood or therapeutic blood fractions.

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[1] The number of facilities reported in other documents may differ from the 35 facilities reported here as a result of differences in definitions for the term "facility".

Out-patient services include:

- laboratory and radiological examinations;
- diagnostic procedures involving the use of radio-pharmaceuticals;
- electroencephalographic examinations;
- use of occupational and physiotherapy facilities, where available;
- necessary nursing services;
- drugs, biologicals and related preparations;
- blood or therapeutic blood fractions;
- hospital services in connection with most minor medical and surgical procedures;
- day-patient diabetic care;
- services other than medical services provided by and within the Nova Scotia Hearing and Speech Clinics;
- ultrasonic diagnostic procedures;
- home parenterel nutrition; and
- haemodialysis and peritoneal dialysis.

In order to add a new hospital service to the list of insured hospital services, District Health Authorities are required to submit a New and/or Expanded Program Proposal to the Department of Health. This process is carried out annually by request through the business planning process. A Department-developed process format is forwarded to the Districts for their guidance. A Department working group reviews and prioritizes all requests received. Based on available funding, a number of top priorities may be approved by the Minister of Health.

2.2 Insured Physician Services

The legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35 and the Medical Services Insurance Regulations.

The *Health Services and Insurance Act* was amended in 2002–2003 to include section 13B stating that: "Effective November 1, 2002, any agreement between a provider and a hospital, or predecessors to a hospital, stipulating compensation for the provision of insured professional services, for the provider undertaking to be on-call for the provision of such services or for the provider to relocate or maintain a presence in proximity to a hospital, excepting agreements to which the Minister and the Society are a party, is null and void and no compensation is payable pursuant to the agreement, including compensation otherwise payable for termination of the agreement."

Under the *Health Services and Insurance Act*, persons who can provide insured physician services include: general practitioners, who are persons who engage in the general practice of medicine; physicians, who are not specialists within the meaning of the clause; and specialists, who are physicians and are recognized as specialists by the appropriate licensing body of the jurisdiction in which he or she practises.

Physicians(general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2006–2007, 2,282 physicians and 29 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2007, no physicians had opted out.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

No new large-scale services were added to the list of insured physician services in 2006–2007. On an as needed basis, new specific fee codes are approved that represent enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established must first present their cases to Doctors Nova Scotia, which puts a suggested value on the proposed new fee.

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from Doctors Nova Scotia and the Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Medavie Blue Cross Care is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the *Nova Scotia Health Services and Insurance Act*, a dentist is defined as a person lawfully entitled to practice dentistry in a place where such practice is carried on by that person.

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2007, no dentists had opted out. In 2006–2007, 29 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the Insured Dental Services Tariff Regulations. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of a surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Requests for an addition to the list of surgical-dental services are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

Effective February 15, 2005. "Other extraction services" (routine extractions) at public expense were approved for the following groups of patients, 1) cardiac patients, 2) transplant patients, 3) immunocompromised patients, and 4) radiation patients.

Routine extractions for these patients will be provided at public expense when and only when, the following criteria have been met. These patients must be undergoing active treatment in a hospital setting and the attendant medical procedure must require the removal of teeth that would otherwise be considered routine extractions and not paid at public expense. It is critical/vital to the claims approval process that the dental treatment plans include the name of the Medical Specialist providing the care and that he/she has indicated in writing in the patient's medical treatment plan that the routine dental extractions are required prior to performing the medical treatment/procedure.

Other newly approved service includes coverage for all precancerous or cancerous dental surgical biopsies.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- preferred accommodation at the patient's request;
- telephones;
- televisions;
- drugs and biologicals ordered after discharge from hospital;
- cosmetic surgery;
- reversal of sterilization procedures;
- surgery for sex reassignment;
- in-vitro fertilization;
- procedures performed as part of clinical research trials;
- services such as gastric bypass for morbid obesity, breast reduction/augmentation and newborn circumcision, except because of medical necessity; and
- services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:

- those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;
- mileage, traveling or detention time;
- telephone advice or telephone renewal of prescriptions;
- examinations required by third parties;
- group immunizations or inoculations unless approved by the Department;
- preparation of certificates or reports;
- testimony in court;
- services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty;
- cosmetic surgery;
- acupuncture;
- reversal of sterilization; and
- in-vitro fertilization.

Major third party agencies purchasing medically necessary health services in Nova Scotia include Workers' Compensation, Canadian Force and RCMP.

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as foldable intraocular lens or a fiberglass cast can be purchased, it is required to fully inform patients about the cost. They are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

The Department of Health also carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

The de-insurance of insured physician services is accomplished through a negotiation process between the Medical Society of Nova Scotia and the Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Regulations made pursuant to section 17 of the *Health Services and Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

A person is considered to be "ordinarily present" in Nova Scotia if the person:

- makes his or her permanent home in Nova Scotia;
- is physically present in Nova Scotia for at least 183 days in any calendar year (short term absences under 30 days, within Canada, are not monitored); and
- is a Canadian citizen or "Permanent Resident" as defined by Citizenship and Immigration Canada.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the province, provided they are Canadian citizens or hold "Permanent Resident" status as defined by Citizenship and Immigration Canada.

Members of the RCMP, members of the Canadian Forces and federal inmates are ineligible for MSI coverage. When their status changes, they immediately become eligible for provincial Medicare.

There were no changes to eligibility requirements in 2006–2007.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Once eligibility has been determined, an application form is generated. The applicant (and spouse if applicable) must sign the form before it can be processed. The applicant must indicate on the application the name and mailing address of a witness. The witness must be a Nova Scotia resident who can confirm the information on the application. The applicant must include proof of Canadian citizenship or provide a copy of an acceptable immigration document.

When the application has been approved, health cards will be issued to each family member listed. MSI registration information is maintained as a family unit. Each health card number is unique and is issued for the lifetime of the applicant. Health cards expire every four years. The health card number also acts as the primary health record identifier for all health service encounters in Nova Scotia for the life of the recipient. Proof of eligibility for insured services is required before residents are eligible to receive insured services. Renewal notices are sent to most cardholders three months before the expiry date of the current health card. Upon return of a signed renewal notice, MSI will issue a new health card.

There is no legislation in Nova Scotia forcing residents of the province to apply for MSI. There may be residents of Nova Scotia who, therefore, are not members of the health insurance plan.

In 2006–2007, the total number of residents registered with the health insurance plan was 965,044.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia, once they meet the specific eligibility criteria for their situations:

Immigrants: Persons moving from another country to live permanently in Nova Scotia, are eligible for health care on the date of arrival. They must possess a landed immigrant document. These individuals, formerly called "landed immigrants", are now referred to as "Permanent Residents".

Convention Refugees and Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied within Canada for Permanent Resident status, will be eligible on the date of application for Permanent Resident status — provided they possess a letter or documentation from the Immigration Department stating that they have applied for Permanent Residence.

Non-Canadians married to Canadian Citizens/ Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied outside Canada for Permanent Resident status, will be eligible on the date of arrival — provided they possess a letter or documentation from the Immigration Department stating that they have applied for Permanent Residence.

In 2006–2007, there were 23,886 Permanent Residents registered with the health care insurance plan.

Work Permits: Persons moving to Nova Scotia from outside the country who possess a work permit can apply for coverage on the date of arrival in Nova Scotia, providing they will be remaining in Nova Scotia for at least one full year. A declaration must be signed to confirm that the worker will not be outside Nova Scotia for more than 31 consecutive days, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time. Each year a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons, who are legally entitled to remain in Canada, are granted coverage on the same basis.

Once coverage has terminated, the person is to be treated as never having qualified for health services coverage as herein provided and must comply with the above requirements before coverage will be extended to him/her—or their dependents.

In 2006–2007, there were 1,560 individuals with Employment Authorizations covered under the health care insurance plan.

Study Permits: Persons moving to Nova Scotia from another country, who possess a Study Permit will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, except in the course of their studies. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons, who are legally entitled to remain in Canada, will be granted coverage on the same basis, once the student has gained entitlement.

In 2006–2007, there were 804 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either a work permit or study permit.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for MSI on the first day of the third month following the month of their arrival.

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students, and their dependants, who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide, to MSI, a letter directly from the educational institution, which states that they are registered as full-time students. MSI coverage will be extended on a yearly basis pending receipt of this letter.

Workers who leave Nova Scotia to seek employment elsewhere will still be covered by MSI for up to 12 months, provided they do not establish residence in another province, territory or country. Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates in the 'Hospital Reciprocal Billing Agreement' and the 'Medical Reciprocal Billing Agreement'. Quebec is the only province that does not participate in the medical reciprocal agreement. Nova Scotia pays for services provided by Quebec physicians to Nova Scotia residents at Quebec rates if the services are insured in Nova Scotia. The majority of such claims are received directly from Quebec physicians. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the plan in 2006–2007, for in- and out-patient hospital services received in other provinces and territories was $22,771,143. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

There were no changes made in Nova Scotia in 2006–2007 regarding in-Canada portability.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident meets eligibility requirements, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. Ordinarily, to be eligible for coverage, residents must not be outside the country for more than six months in a calendar year. In order to be covered, procedures of a non-emergency nature must have prior approval before they will be covered by MSI.

Students and their dependants who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI, a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Persons who engage in employment (including volunteer/missionary work/research) outside Canada, which does not exceed 24 months, are still covered by MSI; providing the person has already met the residency requirements.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent in 2006–2007 for insured in-patient services provided outside Canada was $153,937.17.

There were no changes made in Nova Scotia in 2006–2007 regarding out-of-Canada portability.

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a specialist in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the province, or if it can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's referring specialist. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions. There are no user charges or extra charges under the plan.

Nova Scotia continually reviews access situations across Canada to ensure that it is not falling behind. In areas where improvement is deemed necessary, depending on the Province's financial situation, extra funding is generally allocated to that area. The Department of Health accepted the recommendations of the Provincial Osteoporosis Committee report, which included placing new bone density units in Sydney and Yarmouth and operating the Truro unit at full capacity. In fiscal 2002–2003, an additional $5 million was allocated to the Capital District Health Authority to increase cardiac surgery and cardiac catheterization capability to decrease wait times. In Fiscal 2004/05, $7 million was added to the Capital District budget to address the issue of ever increasing orthopedic wait lists. In fiscal 2004–2005 approval and funding was approved for the purchase of four MRIs to be located in four rural areas: Antigonish, New Glasgow, Kentville, and Yarmouth. In fiscal 2006–2007, MRI services were introduced at the Yarmouth, Kentville, New Glasgow and Antigonish Regional Hospital to increase rural access and reduce provincial wait times. The two MRIs at the Capital District Health Authority in Halifax were also replaced. Capital Health also received approval and funding to establish a Positron Emission Tomography Program (PET/CT). In addition to the PET/CT project that will be operational in February 2008, the province has approved funding for a Cyclotron project to complete access to PET/CT services and the required manufacture of the FDGs (2-[flourine-18]-flouro-2-deoxy-D-glucose) on site to be operational in fiscal 2009–2010.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to emphasize the provision of sustainable, quality health care services to its citizens.

In 2006–2007, a total of $11.0 million in funding was provided to train, recruit and retain nurses. Eighty percent of the nurses from the class of 2002 renewed their licenses, compared with only 51 percent in 2001. This is the highest retention ratio since 1999.

Table 1 provides a breakdown of key health professions that are licensed to practice in Nova Scotia. Not all of these health professionals were actively involved in delivering insured health services.

Table 1: Health Personnel in Nova Scotia[2]

Health Occupation	Registered/Licensed to Practice[3]
Physicians	2,282
Dentists[4]	510
Registered Nurses	9,526
Licensed Practical Nurses	3,274
Medical Radiation Technolologists	537
Respiratory Therapists	186[5]
Pharmacists	1,145
Occupational Therapists	234
Speech-Language Pathologists	155
Chiropractors	107
Opticians	173
Optometrists	97
Denturists	61
Dietitians	447
Psychologists	450
Physiotherapists	390

5.3 Access to Insured Physician and Surgical-Dental Services

In 2006–2007, 2,282 physicians and 29 dentists actively provided insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

The Province has increased the capacity for medical education for both Canadian medical students and internationally educated physicians, coordinates ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the province.

In 2006–2007 the province has also taken the following measures to improve access to insured physician services:

- Nova Scotia invested $11.5 million to upgrade Inverness Hospital. The upgrades will allow residents of Inverness and the surrounding area to have improved access to community health-care services.
- Nova Scotia invested $5.3 million in renovating the Cape Breton Regional Hospital. The renovations will include the addition of cardiac examination and observation rooms, a patient transfer entrance, changes to the nursing station, trauma area improvements, more observation beds, consultation rooms for mental health services, a revised triage area and changes to the emergency ambulance entrance.

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[2] Data are current (2006–2007) except where mentioned.

[3] Not all professionals licensed to practise actually work.

[4] A limited number of licensed dentists are approved for insured dental services.

[5] Data is for year 2002.

- Nova Scotia introduced a new *Registered Nurses Act*. This legislation will better define the scope of practice and how registered nurses work with other health professionals.

  The Act will eliminate the barriers facing nurse practitioners, while following national standards. This will enable them to work in collaboration with other health-care professionals, allowing them to make a diagnosis, order tests and prescribe medications.

  A second piece of legislation, the *Licensed Practical Nurses Act*, clarifies the definition of their scope of practice. This allows them to work more independently with their patients.

About 9,526 registered nurses are licensed by the College of Registered Nurses of Nova Scotia and 3,058 licensed practical nurses are licensed by the College of Licensed Practical Nurses of Nova Scotia.

5.4 Physician Compensation

The *Health Services and Insurance Act*, RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between Doctors Nova Scotia and the Nova Scotia Department of Health. Doctors Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from Doctors Nova Scotia and the Department of Health negotiate the total funding and other terms and conditions. The current master agreement is effective from April 1, 2004 through March 31, 2008. The agreement lays out what the medical services unit value will be for physician services and addresses other issues such as Canadian Medical Protective Association, membership benefits, emergency department payments, on-call funding, specific fee adjustments, dispute resolution processes, and other process or consultation issues.

Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of alternative payment arrangements in place in Nova Scotia.

Over the past number of years, we have seen a significant shift toward alternative payment. In the 1997–1998 fiscal year, about 9 percent of our doctors were paid solely through alternative funding. In 2006–2007 it is estimated that over 30 percent of physicians continue to be remunerated through alternative funding. They can be broken down into three groups:

1) **Academic Specialists** — (these physicians are mainly located in Halifax at the QEII and the IWK centres). Most of the Academic Specialist groups are on alternate funding arrangements with the exception of Urology and Ophthalmology.
2) **District Specialists** — (Obstetrics/Gynecology, Anaesthesiology, Pediatrics).
3) **General Practice** (including General Practice/ Nurse Practitioner Contracts).

There are also a number of physicians who receive a portion of their remuneration through alternative funding. These alternative funding mechanisms include Sessional, Psychiatry, Remote Practice, Facility On-Call and Emergency Room funding. In total, over 60 percent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms.

In 2006–2007 total payments to physicians for insured services in Nova Scotia were $581,817,423. The Department paid an additional $7,091,572 for insured physician services provided to Nova Scotia residents outside the province, but within Canada.

Payment rates for dental services in the province are negotiated between the Department of Health and the Nova Scotia Dental Association and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement, which was reached in April 2004, expires on March 31, 2008.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine District Health Authorities (DHAs), the IWK Health Centre and other non-DHA organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* was given Royal Assent on June 8, 2000. The Act instituted the nine DHAs that replaced the former regional health boards. This change came into effect in January 2001, under the District Health Authorities General Regulations. The implementation of community health boards under the Community Health Boards' Member Selection Regulations was effective April 2001. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the Hospital Insurance Regulations define the terms for payments by the Minister of Health to hospitals for insured hospital services.

In 2006–2007, there were 2,891 hospital beds in Nova Scotia (3.0 beds per 1,000 population). The Department of Health's direct expenditures for insured hospital services operating costs were increased to $1.12 Billion.

6.0 Recognition Given to Federal Transfers

In Nova Scotia, the *Health Services and Insurance Act* acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware of ongoing federal contributions to Nova Scotia health care through the Canada Health Transfer (CHT) as well as other federal funds through press releases and media coverage.

The Government of Nova Scotia also recognized the federal contribution under the CHT in various published documents including the following documents released in 2006–2007:

- Public Accounts 2006–2007; and
- Budget Estimates 2006–2007.

7.0 Extended Health Care Services

The Nova Scotia Department of Health's Continuing Care branch offers home care and long-term care services. These services promote independence, fairness, equity, and choice for people with care needs. The Department of Health provides a Single Entry Access to its continuing care services. Nova Scotians can connect with Continuing Care through a single toll-free number.

In 2006, the Department of Health released a broad based, multi-year Continuing Care strategy that will see the addition of long-term care beds and the expansion and enhancement of community and home based services over the ensuing five to ten years.

7.1 Nursing Home Intermediate Care and Adult Residential Care Services:

- The Department of Health provides residentially based long-term care services in the following facility types:

  Nursing Homes & Homes for the Aged which provide a range of personal care and/or skilled nursing care to individuals who require the availability of a registered nurse on-site at all times;

  Residential Care Facilities which provide supervisory care and/or personal care in a residential setting; and

  Community Based Options which provide accommodation, minimal supervision and the development of self-care skills for three or less residents.

Residents who live in nursing homes, residential care facilities, and community-based options under the Department of Health's mandate have the costs of their health care services covered by the provincial government. Residents pay the accommodation cost portion of the long-term care services they receive. Long-term care accommodation charges are based on the type of facility and the resident's income, up to a daily maximum. For more information please see:

www.gov.ns.ca/health/ccs/ltc.htm

7.2 Home Care Services:

Broad-based, provincially funded home care services are available to Nova Scotians of all ages and help individuals to reach and maintain their maximum level of health and to prolong independent living in the community. Both chronic care services over the longer term and short-term acute services are provided through home care. Home care services can be provided to people who are chronically ill, convalescent, palliative, disabled or to individuals with an acute illness. The services available to individuals through home care include professional nursing care, assistance with personal care, nutritional care, aid with home making activities, home oxygen services and respite care. The program also provides referrals to and linkages with other services such as adult day programs, volunteer services, meals on wheels and community rehabilitation services.

In December 2005, the Department of Health introduced a Self-Managed Care service component to assist physically disabled Nova Scotians to increase control over their lives. The program provides funds to eligible individuals so that they may directly employ caregivers to meet their home support and personal care needs.

In addition to the services outlined above, the following services and programs are provided to Nova Scotians outside the requirements of the *Canada Health Act*.

- **Nova Scotia Seniors' Pharmacare Program** — This provincial drug insurance plan helps seniors manage their prescription drug costs. Eligible persons include all residents aged 65 years or older and who do not have prescription drug coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan. The program provides access to prescription drugs, and diabetic and ostomy supplies listed as benefits in the Nova Scotia Formulary. Persons using this program are responsible for user charges of 33 percent of the total cost to a maximum of $30 for each drug and supply with an annual maximum of $360. General information regarding Pharmacare can be found at:

  www.gov.ns.ca/health/pharmacare/default.htm

- **Special Funding for Drugs for Specific Disease States** — The Province provides special funding for drug therapies for a few specific disease states including cystic fibrosis, diabetes insipidus, cancer and growth hormone deficiency. There are no user charges for this coverage. General information regarding Drug Programs and Funding can be found at:

  www.gov.ns.ca/health/pharmacare/default.htm

- **Diabetes Assistance Program.** In 2005–2006, $2.5 million was allocated to design and start this program. This program helps cover the cost of most diabetes medications and supplies and is available to Nova Scotians under 65 years of age who have no other drug coverage. General information on this program is available at:

  http://www.gov.ns.ca/health/pharmacare/dap/default.htm
- **Emergency Health Services** — Pre-hospital Emergency Care — Emergency Health Services Nova Scotia (EHS) is responsible for the continual development, implementation, monitoring and evaluation of pre-hospital emergency health services in Nova Scotia. EHS integrates various pre-hospital services and programs into one system to meet the needs of Nova Scotians. These services include: EHS ground ambulance system, EHS LifeFlight (the provincial air medical transport system), EHS Communications Centre, Medical Oversight (Management and Direction), the EHS NS Trauma Program, EHS Atlantic Health Training and Simulation Centre and the EHS Medical First Response program. This integrated province-wide system has been rated in the top 10 percent of systems in North America. Residents in Nova Scotia are levied a user charge of $120, to be transported to hospital by ambulance (regardless of distance). There is no charge for transport from hospital to hospital.
- **Children's Oral Health Program (COHP)** — This program has two components: 1) the Insured Services Treatment component provides diagnostic, preventative and restorative services; and 2) the Public Health Services component provides prevention-oriented activities through the application of public health initiatives. Children are eligible for services up to the end of the month in which they turn 10 years of age. All eligible children are entitled to one dental examination and two radiographs per year.
- **Special Dental Plans** — The program covers all dental services required, including prosthetics and orthodontics required by persons diagnosed as having a cleft palate cranofacial disorder; in-hospital dental services provided to the severely mentally challenged who, because of their condition, require the services to be provided in hospital; and a full range of diagnostic, preventive and restorative procedures to residents of the Nova Scotia School for the Blind. There are no user charges for these services. Eligible residents include the following: 1) patients registered with the Cleft Palate Cranofacial Clinic at the IWK Health Centre; 2) registered students at the School for the Blind; and 3) patients with a signed statement to the effect that they are severely mentally challenged and require hospitalization for dental treatment.
- **Community Mental Health Program** — All of the DHAs and the IWK Health Centre offer acute psychiatric treatment. Services are provided across the life span of a person. Specialized services are offered and are in-patient, day treatment, and community-based (e.g. forensic, eating disorders, psychogeriatrics and psychosocial rehabilitation). There are early intervention programs for children with Autism Spectrum Disorder (0–6 yrs). Intensive Community Based Treatment teams in two DHAs and one provincial Mental Health residential/rehabilitation program for children and youth exists to enhance the continuum of mental health services. Youth Forensic services, including a treatment program for Sexually Aggressive Youth, exist under the authority of the IWK Health Centre. There are no user charges for these services. They are available to all residents in the province.

- **Nova Scotia Addiction Services** — A range of treatment and rehabilitation options are provided, including withdrawal management (detoxification and treatment orientation) programs and community-based structured treatment, out-patient and extended care services. Treatment options are tailored to individual needs and are based on an ongoing assessment. Short-term and long-term treatment goals are identified with each client. Programs and services may be available on a residential, day or out-patient basis, and may include individual, group and/or family programming. Targeted programming is offered where appropriate and may include programming for adolescents, women, families or impaired drivers. There are no user charges for these services except for the program for Driving While Impaired Offenders.
- **Optometric Benefit** — This benefit provides insurance for visual analysis carried out by optometrists. Vision analysis is defined as: "... an examination that includes the determination of: 1) the refractive status of the eye; 2) the presence of any observed abnormality in the visual system, and all necessary tests and prescriptions connected with such determination." Coverage is limited to one routine vision analysis every two years for those under 10 years of age and those 65 and over. Those between 10 and 65 are not covered for routine analyses, but are covered where medical need is indicated.
- **Prosthetic Services** — All insured residents of the province are eligible for financial assistance in acquiring and replacing standard arm and leg prostheses prescribed by a qualified physician and repairs on such prostheses as required. Patients are responsible for all costs over and above stated coverage.
- **Interpreter Service Program** — This program guarantees equal access to government services, offered to the general public, to eligible deaf and hard of hearing residents of Nova Scotia.
- **Speech and Language Pathology Program** — The service options of this program include: 1) one-to-one therapy; 2) small-group therapy; and 3) consultations (e.g. classroom, day-cares developmental preschools, and residential facilities for individuals with special needs). The Nova Scotia Hearing and Speech Centres provide specialized services such as dysphagia (swallowing) programs and pervasive developmental delay programs at limited locations in the province. There are no user charges. Eligible persons include children from birth to school age and individuals when they leave school through their adult lifespan. Provincial school boards service children in the public school system.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	955,475	956,820	961,089	963,993	965,044

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#): a. acute care b. chronic care c. rehabilitative care d. other e. total	 35 not applicable not applicable not applicable 35	 35 not applicable not applicable not applicable 35	 35 not applicable not applicable not applicable 35	 35 not applicable not applicable not applicable 35	 35 not applicable not applicable not applicable 35
3. Payments for insured health services ($):[6] a. acute care b. chronic care c. rehabilitative care d. other e. total	 1,021,934,504 not applicable not applicable not applicable 1,021,934,504	 1,095,584,706 not applicable not applicable not applicable 1,095,584,706	 1,133,215,533 not applicable not applicable not applicable 1,133,215,533	 1,230,549,093 not applicable not applicable not applicable 1,230,549,093	 1,301,306,116 not applicable not applicable not applicable 1,301,306,116
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#): a. surgical facilities b. diagnostic imaging facilities c. total	 1 0 1	 1 0 1	 0 1 1	 0 1 1	 0 1 1
5. Payments to private for-profit facilities for insured health services ($): a. surgical facilities b. diagnostic imaging facilities c. total	 11,714 0 0	 5,531 0 5,531	 0 not available not available	 0 not available not available	 0 not available not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	2,300	2,368	2,335	2,252	2,154
7. Total payments, in-patient ($).	12,685,659	15,859,930	15,795,451	16,285,032	14,502,141
8. Total number of claims, out-patient (#).	34,425	32,968	34,166	37,811	41,729
9. Total payments, out-patient ($).	4,447,816	4,303,236	6,107,316	7,345,702	8,269,002
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	not available	not available	not available	not available	not available
11. Total payments, in-patient ($).	938,092	623,896	678,205	1,495,313	727,586
12. Total number of claims, out-patient (#).	not applicable	not applicable	not applicable	not available	not available
13. Total payments, out-patient ($).	not applicable	not applicable	not applicable	not available	not available

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[6] $'s are paid to acute care facilities/DHAs only.

Insured Physician Services Within Own Province or Territory	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	875	904	905	948	944
b. specialists	1,142	1,198	1,235	1,270	1,333
c. other	9	14	27	2	5
d. total	2,026	2,116	2,167	2,220	2,282
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	9,323,272	9,199,462	9,290,207	9,599,128	9,569,146
b. total payments ($)	398,328,065	434,000,386	464,685,571	540,495,196	581,817,423
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	6,243,934	6,560,930	6,353,382	6,553,774	6,357,622
b. total payments ($)	241,362,772	254,670,965	246,724,107	254,621,655	255,007,711

Insured Physician Services Provided to Residents in Another Province or Territory	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	187,390	180,897	188,118	198,262	205,237
20. Total payments ($).	5,562,125	5,747,516	5,866,887	6,619,938	7,091,572
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	2,748	2,667	3,111	2,981	2,931
22. Total payments ($).	121,780	120,977	151,175	151,414	153,937

Insured Surgical-Dental Services Within Own Province or Territory	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	36	28	25	33	29
24. Number of services provided (#).	5,188	3,780	4,343	5,169	5,321
25. Total payments ($).	939,004	904,283	995,966	1,060,006	1,122,126

New Brunswick

Introduction

New Brunswick's ongoing commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility in health care services — the principles that form the foundation of the *Canada Health Act* — was reaffirmed during the 2006–2007 fiscal year as the Government of New Brunswick implemented the health portions of the *Charter for Change*. The *Charter* is a key priority of New Brunswick's new provincial government, which took office in September 2006, and will guide The Department of Health in setting its key goals, principles, strategies and priorities to guide the health care investments and improvements.

Total funding for the Department of Health in 2006–2007 was a record $1.927 billion, representing an increase of $154 million over the previous year. Investments have increased in all areas of health care, including hospital services, Medicare, the Prescription Drug Program and ambulance services.

As New Brunswick is Canada's only officially bilingual province, the Department has engaged in consultation sessions to determine the needs of Francophone communities. The recommendations from this Dialogue Santé are currently being implemented. In 2007, the Government released its Rural Health Framework, which is designed to improve health care services in rural areas. Initiatives under this program include the recruitment, retention, and continuing education of rural health providers, and increasing the level of primary care services in rural areas. Emergency medical services are being enhanced with the creation of a single ambulance service for the province. The Government of New Brunswick is moving toward the development of electronic health records and is in the process of updating its health information privacy legislation.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the health care insurance plan is known as the Medical Services Plan. The public authority responsible for operating and administering the plan is the Minister of Health, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured and the uninsured services. The legislation also stipulates the type of agreements the provincial authority may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner; how the amounts to be paid for entitled services will be determined; how assessment of accounts for entitled services may be made; and confidentiality and privacy issues as they relate to the administration of the Act.

1.2 Reporting Relationship

The Medicare Services Branch and the Medicare Operations Branch of the Department of Health are mandated to administer the Medical Services Plan. The Minister reports to the Legislative Assembly through the Department's annual report and through regular legislative processes.

The *Regional Health Authorities Act*, which came into force on April 1, 2002, sets out the relationship between the eight Regional Health Authorities (RHAs) and the Department. Under the Act, RHAs must prepare regional health and business plans that are in harmony with the Provincial Health Plan developed by the Department. The business and affairs of the RHA are to be controlled and managed by a board of directors, appointed or elected in accordance with the Act and its regulations. The chief executive officer of each RHA reports to the Deputy Minister of Health. Under sections 7(1) and 7(2) of the Act, the Minister of Health shall establish an accountability framework, drafted in consultation with RHAs, to specify the responsibilities that each party has to the other in the provincial health system.

1.3 Audit of Accounts

Three groups have a mandate to audit the Medical Services Plan.

1) The Office of the Auditor General: In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which includes the financial records of the Department of Health. For 2006–2007, all financial transactions of the Department were subject to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report to identify errors and control weaknesses. The Auditor General also conducts management reviews on programs as he or she sees fit and follows up on prior years' audits.
2) The Office of the Comptroller: The Comptroller is the chief internal auditor for the Province of New Brunswick and provides accounting, audit and consulting services in accordance with responsibilities and authority set out in the *Financial Administration Act*. The Comptroller's internal audit objectives cover Appropriations Audits, Information Systems Audits, Statutory Audits and Value-For-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited and the audit objectives. During 2006–2007, the Office of the Comptroller continued to gather risk assessment data on programs offered by the Department and reviewed common services in the Department and other selected departments.
3) Department of Health Internal Audit Branch: The Department's Internal Audit Branch was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing departmental management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The Branch also performs program audits to report on the efficiency, effectiveness and economy of programs in meeting departmental objectives.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, 1973, and section 9 of Regulation 84-167 and the *Hospital Act*, assented to on May 20, 1992, and its Regulation 92-84.

There are eight Regional Health Authorities (RHAs), established under the authority of the *Regional Health Authorities Act*. Each RHA includes a regional hospital facility and a number of smaller facilities, all of which provide insured services for both in- and out-patients. Each RHA has other facilities or health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

Under Regulation 84-167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following in-patient and out-patient insured hospital services.

In-patient services in a hospital facility operated by an approved RHA as follows:

- accommodation and meals at the standard ward level;
- necessary nursing service;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability;
- drugs, biological and related preparations, as provided for under Schedule 2;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, and routine surgical supplies;
- use of radiotherapy facilities, where available;
- use of physiotherapy facilities, where available; and
- services rendered by persons who receive remuneration therefore from the RHA.

Out-patient services in a hospital facility operated by an approved RHA as follows:

- laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner or nurse practitioner, when approved facilities are available;
- laboratory and diagnostic procedures, together with the necessary interpretations, where approved facilities are available, when performed for the purpose of a mammography screening service that has been approved by the Minister of Health;
- the hospital component of available out-patient services when prescribed by a medical practitioner or nurse practitioner and provided in an out-patient facility of an approved RHA, for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability, excluding the following services:
    - the provision of any proprietary medicines;
    - the provision of medications for the patient to take home;
    - diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;
    - visits solely for the administration of drugs, vaccines, sera or biological products; and
    - any out-patient service that is an entitled service under the *Medical Services Payment Act.*

During fiscal 2006–2007, the Department added PET/CT services for oncology patients, who meet pre-determined criteria, to the list of insured services.

The process for adding a hospital service to the list of insured services involves the Department of Health receiving a proposal from a Regional Health Authority or other stakeholder, which is then screened for eligibility against the criteria for insured hospital services described under the *Hospital Services Act* and its regulations.

2.2 Insured Physician Services

The enabling legislation providing for insured physician services is the *Medical Services Payment Act.*

The Act was given Royal Assent on December 6, 1968. Regulation 84-20 was filed on February 13, 1984. Regulation 93-143 was filed on July 26, 1993. Regulation 96-113 was filed on November 29, 1996, since repealed and replaced with 2002-53, filed on June 28, 2005, and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13, 1999.

No changes pertaining to physician services were introduced to this Act and regulations during fiscal 2006–2007.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions that a physician must meet to participate in the New Brunswick Medical Services Plan are:

- maintain current licensure with the New Brunswick College of Physicians and Surgeons;
- maintain membership in the New Brunswick Medical Society;

- hold privileges in an RHA; and
- have signed the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's Medical Services Plan as of March 31, 2007, was 1,411.

Physicians in New Brunswick have the option to opt out totally or for selected services. Totally opted-out practitioners are not paid directly by Medicare for the services they render and must bill patients directly in all cases. Patients are not entitled to reimbursement from Medicare for services rendered by totally opted-out physicians.

The selective opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. Opted-in physicians wishing to opt out for a service must first obtain the patient's agreement to be treated on an opted-out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The physician must advise the patient in advance and:

- the charges must not exceed the Medicare tariff. The practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged to the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare.
- if the charges will be in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:
  - they are opting out and charging fees above the Medicare tariff;
  - in accepting service under these conditions, the beneficiary waives all rights to Medicare reimbursement; and
  - the patient is entitled to seek services from another practitioner who participates in the Medical Services Plan.

The physician must obtain a signed waiver from the patient on the specified form and forward that form to Medicare.

As of March 31, 2007, no physicians rendering health care services had elected to completely opt out of the New Brunswick Medical Services Plan.

The range of entitled services under Medicare includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital facility. The range of non-entitled services is set out under Schedule 2, Regulation 84-20, *Medical Services Payment Act.*

An individual, a physician or the Department may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and Canada. Considerations under the term "medically necessary" include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

During fiscal 2006–2007, the following physician services were added:

- Repair Closure of Abdominal Wall
- Sacral Afferent Nerve Stimulation (SANS)
- Paediatric Chemotherapy
- Evaluation of Child Abuse
- Paediatric Coloscopy
- Suburethral Prosthetic Sling — TVT, SPARC
- Pelvic Ultrasound
- Narrow Band UV Therapy
- Heidelberg Retinal Tomography (HRT)
- Mohs Micrographic Surgery

- Capsule Endoscopy
- PET-CT scans
- Surgical Prioritization Tool Completion

2.3 Insured Surgical-Dental Services

Schedule 4 of Regulation 84-20 (filed June 23, 1998, under the *Medical Services Payment Act*) identifies the insured surgical-dental services that can be provided by a qualified dental practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital. In addition, a general dental practitioner may be paid to assist another dentist for medically required services under some conditions.

The conditions that a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the New Brunswick Medicare Dental registration form).

As of March 31, 2007, there were 85 dentists registered with the Plan.

Dentists have the same opting out provision as physicians (see section 2.2) and must follow the same guidelines. The Department has no data for the number of non-enrolled dental practitioners in New Brunswick.

New Brunswick expanded the role of Oral Maxillofacial Surgeons (OMS) in the province by amending the *Medical Services Payment Act* and Regulations to provide payment for entitled services when they admit and discharge patients and perform physical examinations. The range of services and procedures was expanded and includes those done in an outpatient setting.

The conditions that an OMS must meet to participate in the New Brunswick Medical Services Plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician's Agreement (included in the New Brunswick Medicare Dental registration form).

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include the following: patent medicines; take-home drugs; third-party requests for diagnostic services; visits to administer drugs, vaccines, sera or biological products; televisions and telephones; preferred accommodation at the patient's request; and hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act.*

Services are not insured if provided to those entitled under other statutes.

The services listed in Schedule 2 of New Brunswick Regulation 84-20 under the *Medical Services Payment Act* are specifically excluded from the range of entitled medical services under Medicare, namely:

- elective surgery or other services for cosmetic purposes;
- correction of inverted nipple;
- breast augmentation;
- otoplasty for persons over the age of 18;
- removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
- abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;
- surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in removing the cataract itself, due to the existence of an illness or other complication;
- medicines, drugs, materials, surgical supplies or prosthetic devices;
- vaccines, serums, drugs and biological products listed in sections 1006 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;

- advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
- examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
- dental service provided by a medical practitioner;
- services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
- services that are provided in conjunction with, or in relation to, the services referred to above;
- testimony in a court or before any other tribunal;
- immunization, examinations or certificates for travel, employment, emigration, insurance purposes, or at the request of any third party;
- services provided by medical practitioners or oral maxillofacial surgeons to members of their immediate family;
- psychoanalysis;
- electrocardiogram (ECG) where not performed by a specialist in internal medicine or paediatrics;
- laboratory procedures not intended as part of an examination or consultation fee;
- refractions;
- services provided within the province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;
- the fitting and supplying of eyeglasses or contact lenses;
- transsexual surgery;
- radiology services provided in the province by a private radiology clinic;
- acupuncture;
- complete medical examinations when performed for a periodic check-up and not for medically necessary purposes;
- circumcision of the newborn;
- reversal of vasectomies;
- second and subsequent injections for impotence;
- reversal of tubal ligations;
- intrauterine insemination;
- bariatric surgery unless the person (i) has a body mass index of 40 or greater, (ii) has obesity-related comorbid conditions, and (iii) has, under the supervision of a medical practitioner, commenced and failed an exercise and diet program to reduce the person's weight to a more acceptable level; and
- venipuncture for the purpose of taking blood when preformed as a stand-alone procedure in a facility that is not an approved hospital facility.

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

There are no specific policies or guidelines, other than the Act and regulations, to ensure that charges for uninsured medical goods and services (i.e., enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.), provided in conjunction with an insured health service, do not compromise reasonable access to insured services. Intraocular lenses are now provided by the hospitals.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical service plans across the country and the previous use of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any changes to the Regulation until the advice and recommendations of the New Brunswick Medical Society are received or until the period within which the Society was requested by the Minister of Health to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

No medical or surgical-dental services were removed from the insured service list in fiscal 2006–2007.

3.0 Universality

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and its Regulation 84-20, define eligibility for the health care insurance plan in New Brunswick.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or valid Canadian immigration document. A resident is defined as a person lawfully entitled to be, or to remain, in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient, or visitor to the province.

All persons entering or returning to New Brunswick (excluding children adopted from outside Canada) have a waiting period before becoming eligible for Medicare coverage. Coverage commences on the first day of the third month following the month of arrival.

Residents who are ineligible for Medicare coverage include:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police (RCMP);
- inmates of federal prisons;
- persons moving to New Brunswick as temporary residents;
- a family member who moves from another province to New Brunswick before other family members move;
- persons who have entered New Brunswick from another province to further their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian authorization permits (e.g., a Student Authorization).

Provisions to become eligible for Medicare coverage include:

- non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to, or in a common-law relationship with, an eligible New Brunswick resident.

Provisions when status changes include:

- persons who have been discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided that they are residing in New Brunswick at the time, these persons are eligible for coverage on the date of their release. They must complete an application, provide the official date of release and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependants under the age of 19, on a form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependants are registered and a Medicare card with an expiry date is issued to the beneficiary and each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two or three months before the expiry date of the Medicare card or cards. A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and return the form to Medicare. Upon receiving the completed form, the file is updated and new card(s) are issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are registered.

All family members (the beneficiary, spouse and dependents under the age of 19) are required to register as a family unit. Residents who are cohabiting, but not legally married, are eligible to register as a family unit if they so request.

Residents may opt out of Medicare coverage if they choose. They are asked to provide written confirmation of their intention. This information is added to their files and benefits are terminated.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible, provided that they are legally married to, or living in a common-law relationship with, an eligible New Brunswick resident and still possess a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period to obtain eligibility for Medicare coverage in New Brunswick. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution who leave New Brunswick to further their education in another province are granted coverage for a 12-month period that is renewable provided that they do the following:

- provide proof of enrolment;
- contact Medicare once every 12-month period to retain their eligibility;
- do not establish residence outside New Brunswick; and
- do not receive health coverage in another province.

Residents temporarily employed in another province or territory are granted coverage for up to 12 months provided that they do the following:

- do not establish residence in another province;
- do not receive coverage in another province; and
- intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the province or territory where they are employed and should be entitled to receive coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all Canadian provinces and territories for reciprocal billing of insured hospital services. As well, New Brunswick has reciprocal agreements with all provinces except Quebec for the provision of insured physicians' services. Services provided by Quebec physicians to New Brunswick residents are paid at Quebec rates, if the service delivered is insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient, according to New Brunswick regulations.

There were 192,544 physician services provided to New Brunswick residents in other provinces and territories as of March 31, 2007. The total amount paid for these services was $11,125,487.

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act*, Regulation 84-20, sections 3(4) and 3(5).

Eligibility for "temporarily absent" New Brunswick residents is determined in accordance with the *Medical Services Payment Act* and Regulations and the Inter-Provincial Agreement on Eligibility and Portability.

Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12-month period, provided they do not establish residence outside Canada.

Any absence over 182 days, whether it is for work purposes or vacation, would require the Director's approval. This approval can only be up to 12 months in duration and will only be granted once every three years. Families of workers temporarily employed outside Canada will continue to be covered, provided that they reside in New Brunswick.

New Brunswick residents who exceed the 12 month extension have to reapply for New Brunswick Medicare upon their return to New Brunswick, and be subject to the legislated three month waiting period. However, a "grace period" of up to 14 days could be extended to those New Brunswick residents who have been "temporarily absent" slightly beyond the 12 month absence. In some cases this would alleviate having to reapply as a returning resident with the legislated three month waiting period.

Exception for Temporary Workers: Mobile workers are residents whose employment requires them to travel outside the province (e.g., pilots, truck drivers, etc.). Certain guidelines must be met to receive Mobile Worker designation. These are as follows:

- applications must be submitted in writing;
- documentation is required as proof of Mobile Worker status (e.g., letter from employer confirming that frequent travel is required outside New Brunswick; letter from New Brunswick resident confirming that their permanent residence is New Brunswick and how often they return to New Brunswick; copy of resident's New Brunswick drivers license; if working outside Canada, copy of resident's Immigration document that allows them to work outside the country);
- the worker's permanent residence must remain in New Brunswick; and
- the worker must return to New Brunswick during their off-time.

"Mobile Worker" status is assigned for a maximum of two years, after which the New Brunswick resident must reapply and resubmit documentation to confirm continuing "mobile worker" status.

Contract Workers

Any New Brunswick resident accepting a contract out-of-country must supply the following information and documentation:

- letter of request from the New Brunswick resident with their signature, detailing their absence including Medicare number, New Brunswick address, date of departure, destination and forwarding address, reason for absence and date of return; and
- copy of contractual agreement between employee and employer which defines a start date and end date of employment.

"Contract Worker" status is assigned for up to a maximum of two years. Any further requests for contract worker status must be forwarded to the Director of Medicare Services for approval on an individual basis.

Students

Those in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12-month period that is renewable, provided that they do the following:

- provide proof of enrolment;
- contact Medicare, once every 12-month period to retain their eligibility;
- do not establish permanent residence outside New Brunswick; and
- do not receive health coverage elsewhere.

4.4 Prior Approval Requirement

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost.

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided they fulfill the following requirements:

- the required service, or equivalent or alternate service, must be unavailable in Canada;
- it must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (guide to United States hospitals, health care systems, networks, alliances, health organizations, agencies and providers);
- the services must be rendered by a medical doctor; and
- the service must be an accepted method of treatment recognized by the medical community and be regarded as scientifically proven in Canada. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. A physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation from a Canadian specialist or specialists.

The following are considered exemptions under the out-of-country coverage policy:

- haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the inter-provincial rate of $220 per session; and
- allergy testing for environmental sensitivity: all tests outside the country will be paid at a maximum rate of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required to refer patients to psychiatric hospitals and addiction centres outside the province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received by Medicare from the Addiction Services or Mental Health branches of the Department of Health.

5.0 Accessibility

5.1 Access to Insured Health Services

New Brunswick charges no user fees for insured health services as defined by the *Canada Health Act*. Therefore, all residents of New Brunswick have equal access to these services.

5.2 Access to Insured Hospital Services

The new $28 million Stan Cassidy Centre for Rehabilitation, a facility for treating patients with complex neurological disabilities, was officially opened in Fredericton in June 2006. The new centre has 25 per cent more in-patient beds and almost 30 more clinical and non-clinical staff than the old facility, which was founded in 1957.

Capital investments in hospital services for 2006–2007 included:

- A new mobile MRI unit for patients served by the Restigouche Health Authority, the Acadie-Bathurst Health Authority and the Miramichi Regional Health Authority. This service will enhance the quality of diagnostic images and the ability to offer more services within the regions, including cardiac and advanced breast imaging, services for which patients previously had to travel to other areas to receive.
- New investment totalling $13.723 million in priority medical equipment and technology for hospitals across New Brunswick to provide better access to quality health care and services, including:
    - Regional Health Authority 1 (Beauséjour) — a new cardiac monitoring system, a low-temperature plasma-gas sterilizer, a new CO2 surgery laser. The replacement of this equipment will shorten the wait list, minimize surgical complications and shorten hospitalization.
    - Regional Health Authority 1 (South-East) — a new surgical aspiration system, a low-temperature plasma-gas sterilizer, a magnetic resonance imaging (MRI) monitoring system.
    - Regional Health Authority 2 — 12 new machines used to provide anesthesia and monitor surgical patients, a holmium laser, and eight hemodialysis machines.
    - Regional Health Authority 3 — three new ultrasound machines, and enhancements to a radiographic unit. The upgrade will reduce wait times for radiology assessment.
    - Regional Health Authority 4 — a new general echography unit and a second echography unit to reduce waits time for specialized diagnostic examinations.
    - Regional Health Authority 5 — a new medical transcription and dictation system, and a new cardiac-monitoring system.
    - Regional Health Authority 6 — a new digital radiographic/fluoroscopic unit and an additional ultrasound machine. The additional unit will have an immediate positive impact on the wait time for examinations.
    - Regional Health Authority 7 — a new mobile c-arm radiology unit and a new surgical table for urology. This new unit will provide better access to diagnostic images during urological procedures.
- A third catheterization lab was added to the New Brunswick Heart Centre. This has reduced wait times to meet and exceed nationally recommended wait times.
- The addition of a PET/CT scanner for certain oncology patients. This has improved access; patients previously had to go out-of-province to get this test.
- Chemotherapy services were added for Regional Health Authorities 5 and 6, serving communities in north-eastern New Brunswick.
- A surgical operational review was completed. Implementation of a Provincial Surgical Registry was underway. This is part of an ongoing initiative to improve efficiencies for surgical procedures in order to reduce wait times.

New Brunswick does not have a system to capture in real time the number of nursing positions or staff working in the RHAs. Global budgets are allocated by the Department of Health and managed by the RHAs, and the number and types of nurses are hired to meet the needs of their clientele. The available data includes the number of nurses and licensed practical nurses that were registered in 2006 as employed in New Brunswick. These include insured and non-insured services: 8,041 registered nurses, 22 nurse practitioners, and 2,653 licensed practical nurses.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2007, there were 694 general practitioners, 717 specialists, and 85 dentists registered with the plan.

In fiscal year 2006–2007, the Department continued to work on its recruitment and retention strategy, aimed at attracting newly licensed family practitioners and specialists. This strategy, announced in 1999–2000, included a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities; the provision of location grants for $25,000 for family practitioners and $40,000 for specialists willing to practice in under-serviced areas of the province; and the purchase of five additional seats at the University of Sherbrooke's medical school, which began in September 2002. The recruitment and retention strategy also provides for increased government involvement in post-graduate training of family physicians; the maintenance of 300 weeks in summer rural preceptorship training for medical students; and moving physician remuneration toward relative parity with other Atlantic provinces.

Working with Dalhousie University Medical School and the Regional Health Authority, the Department of Health established an internal medicine residency training program in Saint John. This new program is part of the government's efforts to improve training opportunities for physicians in New Brunswick.

5.4 Physician Compensation

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143 and 96-113.

Fiscal year 2006–2007 marked the second year of an agreement with fee-for-service physicians that provide for a 13 percent increase in fees over a three-year period (2005–2006 to 2007–2008 for 4.0%, 4.5% and 4.5% respectively).

There is no formal negotiation process for dental practitioners in New Brunswick.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary and sessional or alternate payment mechanisms that may also include a blended system.

5.5 Payments to Hospitals

The legislative authorities governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals and the *Hospital Services Act*, which governs the financing of hospitals. The *Regional Health Authorities Act*, which provides for the delivery and administration of health services in defined geographic areas within the province, came into force on April 1, 2002.

There were no changes during the 2006–2007 fiscal year affecting the hospital payment process.

The Department uses two components to distribute available funding to New Brunswick's eight RHAs.

The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:

- tertiary services (cardiac, dialysis, oncology);
- psychiatric services (psychiatric units and facilities);
- dedicated programs (e.g., addictions services);

- community-based services (Extra-Mural Program; health service centres); and
- general patient care.

Added to this are non-patient care support services (e.g., general administration, laundry, food services, energy).

The current budget process may extend over more than one fiscal year and includes several steps. By March of each year, RHAs are to provide the Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current fiscal year. This information, along with the audited financial statements from the previous two fiscal years, is used to evaluate the expected funding level for each RHA.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either recurring or non-recurring bases. The "year-end settlement process" reconciles the total annual approved budget for each RHA to its audited financial statements and reconciles budgeted revenues and expenses to actual revenues and expenses.

Any requests of funding for new programs are submitted to the branch responsible for the new program. An evaluation of the request is performed by Department of Health officials in collaboration with the Regional Health Authority staff.

6.0 Recognition Given to Federal Transfers

New Brunswick routinely recognizes the federal role regarding its contributions under the Canada Health Transfer (CHT) in public documentation presented through legislative and administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on March 13, 2007;
- the 2005-2006 Public Accounts presented by the Minister of Finance on August 16, 2006
- the 2006-2007 Public Accounts presented by the Minister of Finance on September 28, 2007; and
- the Main Estimates presented by the Minister of Finance on March 13, 2007.

New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

The New Brunswick Long-Term Care program, a non-insured service, was transferred to the Department of Family and Community Services on April 1, 2000. Nursing home care, also a non-insured service, is offered through the Nursing Home Services program of the Department of Family and Community Services. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the province.

Nursing homes are private, not-for-profit organizations, except for one facility that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process, based on specific health condition criteria.

Adult Residential Facilities are, for the most part, private and not-for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open and close residential facilities.

Clients are admitted after going through the same evaluation process used for nursing home admissions.

Public housing units are available for low-income elderly persons. Admission criteria are based on age and the applicant's financial situation. The Victorian Order of Nurses offers support services to some units

7.2 Home Care Services

The New Brunswick Extra-Mural Program provides comprehensive home healthcare services throughout the province. Services include acute, palliative, chronic care, rehabilitation services provided in community settings (an individual's home, a nursing home or public school) and a home oxygen program. Since 1996, this program has been delivered by New Brunswick's eight RHAs according to provincial policies and standards.

Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists, speech language pathologists and pharmacists, where funded. These services, although not covered by the *Canada Health Act*, are considered insured services under the provincial Hospital Services Plan.

7.3 Ambulatory Health Care Services

Ambulatory health care services are delivered by New Brunswick's eight RHAs according to provincial policies and standards, and include services provided in hospital emergency rooms, day or night care in hospitals and in clinics if it is available in hospitals, health centres and Community Health Centres. This is considered an insured service under the provincial Hospital Services Plan.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	740,843	741,353	741,726	740,759	738,651

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	27	27	27	23	23
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. other	20	22	22	26	26
e. total	48	50	50	50	50
3. Payments for insured health services ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	954,198,600	1,001,055,724	1,118,701,200	1,205,197,000	1,290,887,880
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#): [1]					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Payments to private for-profit facilities for insured health services ($): [1]					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	4,558	4,785	5,464	5,418	3,740
7. Total payments, in-patient ($).	24,236,513	26,995,076	33,743,005	38,017,578	32,494,834
8. Total number of claims, out-patient (#).	40,823	38,083	34,422	45,907	44,941
9. Total payments, out-patient ($).	5,674,627	5,391,061	5,887,128	9,560,931	10,022,287
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	180	211	191	215	211
11. Total payments, in-patient ($).	420,660	497,715	587,632	374,035	741,599
12. Total number of claims, out-patient (#).	1,001	1,058	1,170	1,453	1,122
13. Total payments, out-patient ($).	244,218	266,167	337,337	321,202	358,594

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[1] There are no private for-profit facilities operating in New Brunswick.

Insured Physician Services Within Own Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#): a. general practitioners b. specialists c. other d. total	 611 649 0 1,260	 647 681 0 1,328	 659 706 0 1,365	 668 714 0 1,382	 694 717 0 1,411
15. Number of opted-out physicians (#): a. general practitioners b. specialists c. other d. total	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available
16. Number of not participating physicians (#): a. general practitioners b. specialists c. other d. total	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available	 not available not available not available not available
17. Services provided by physicians paid through all payment methods: a. number of services (#) b. total payments ($)	 not available 305,027,451	 not available 327,618,344	 not available 351,888,988	 not available 373,500,994	 not available 400,481,139
18. Services provided by physicians paid through fee-for-service: a. number of services (#) b. total payments ($)	 5,693,054 215,626,099	 5,488,314 216,599,016	 5,540,170 229,403,104	 5,721,352 240,841,117	 5,750,695 245,133,979

Insured Physician Services Provided to Residents in Another Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	178,533	200,718	175,516	202,555	192,544
20. Total payments ($).	9,302,399	9,909,950	9,789,130	11,353,739	11,125,487

Insured Physician Services Provided Outside Canada

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
21. Number of services (#).	4,978	5,459	5,339	6,707	6,048
22. Total payments ($).	389,584	428,473	409,132	449,689	417,969

Insured Surgical-Dental Services Within Own Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	28	23	22	21	25
24. Number of services provided (#).	2,301	1,986	2,422	2,890	2,510
25. Total payments ($).	499,769	486,105	537,679	621,491	505,466

Quebec

1.0 Public Administration

1.1 Health Insurance Plan and Public Authority

Quebec's hospital insurance plan, the Régime d'assu rance hospitalisation du Québec, is administered by the ministère de la Santé et des Services sociaux (MSSS) [Quebec Department of Health and Social Services].

Quebec's health insurance plan, the Régime d'assurance maladie du Québec, is administered by the Régie de l'assurance maladie du Québec (RAMQ) [Quebec Health Insurance Board], a public body established by the provincial government and reporting to the Minister of Health and Social Services.

1.2 Reporting

The Public Administration Act (R.S.Q., c. A-6.01) sets out the government criteria for preparing reports on the planning and performance of public authorities, including the ministère de la Santé et des Services sociaux and the Régie de l'assurance maladie du Québec.

1.3 Audit of Accounts

Both plans (the Quebec hospital insurance plan and the Quebec health insurance plan) are operated on a non-profit basis. All books and accounts are audited by the Auditor General of the province.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient services include: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anesthetic facilities; medications, prosthetic and orthotic devices that can be integrated with the human body; biologicals and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital staff.

Out-patient services include: clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery (day surgery); radiotherapy; diagnostic services; physiotherapy; occupational therapy; inhalation therapy, audiology, speech therapy and orthoptic services; and other services or examinations required under Quebec legislation.

Other services covered by insurance are: mechanical, hormonal or chemical contraception services; surgical sterilization services (including tubal ligation or vasectomy); reanastomosis of the fallopian tubes or vas deferens; and ablation of a tooth or root when the health status of the person makes hospital services necessary.

The MSSS administers an ambulance transportation program that is free-of-charge to persons aged 65 or older.

In addition to basic insured health services, the Régie also covers the following, with some limitations, for certain inhabitants of Quebec, as defined by the Health Insurance Act, and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability;

external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for people with a visual or auditory disability; and permanent ostomy appliances.

Since January 1, 1997, in terms of drug insurance, the Régie covers, over and above its regular clientele (employment assistance recipients and persons 65 years of age or older), individuals who otherwise would not have access to a private drug insurance plan. Currently, the drug insurance plan covers 3.17 million insured persons.

2.2 Insured Medical Services

The services insured under this plan include medical and surgical services that are provided by physicians and are required from a medical standpoint.

2.3 Insured Surgical-Dental Services

Services insured under this plan include oral surgery performed in a hospital centre or university institution determined by regulation, by dental surgeons and specialists in oral and maxillo-facial surgery.

2.4 Uninsured Hospital, Medical and Surgical-Dental Services

Uninsured hospital services include: plastic surgery; in vitro fertilization; a private or semi-private room at the patient's request; televisions; telephones; drugs and biologics ordered after discharge from hospital; and services for which the patient is covered under the *Act Respecting Industrial Accidents and Occupational Diseases* or other federal or provincial legislation.

The following services are not insured: any examination or service not related to a process of cure or prevention of illness; psychoanalysis of any kind, unless such service is rendered in an institution authorized for this purpose by the Minister of Health and Social Services; any service rendered solely for aesthetic purposes; any refractive surgery, except in cases where there is documented failure in astigmatism of more than 3.00 diopters or for anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn; any consultation by telecommunication or by correspondence; any service rendered by a professional to his or her spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than one who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes; any service rendered by a professional on the basis of an agreement or a contract with an employer, an association or an organization; any adjustment of eye glasses or contact lenses; any surgical ablation of a tooth or tooth fragment performed by a physician, except where the service is provided in a hospital in certain cases; all acupuncture procedures; injection of sclerosing substances and the examination done at that time; mammography used for screening purposes, unless this service is delivered on a doctor's orders in a place designated by the Minister, in either case, to a recipient who is 35 years of age or older, on condition that such an examination has not been performed on the recipient in the previous year; thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in humans, unless these services are rendered in a hospital centre; ultrasonography, unless this service is rendered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose; any radiological or anesthetic service provided by a physician if required with a view to providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of a radiology service, if required by a person other than a physician or dentist; any sex-reassignment surgical service, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and any services that are not associated with a pathology and that are rendered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim card, for colour blindness or a refraction problem, in order to provide or renew a prescription for eyeglasses or contact lenses.

3.0 Universality

3.1 Eligibility

Registration with the hospital insurance plan is not required. Registration with the Régie de l'assurance maladie du Québec or proof of residence is sufficient to establish eligibility. All persons who reside or stay in Quebec must be registered with the Régie de l'assurance maladie du Québec to be eligible for coverage under the health insurance plan.

3.2 Registration Requirements

Registration with the hospital insurance plan is not required. Registration with the Régie or proof of residence is sufficient to establish eligibility.

3.3 Other Categories of Individual

Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police (RCMP) and inmates of federal penitentiaries are not covered by the Plan. There are no health premium charges.

Certain categories of residents, notably permanent residents under the *Immigration Act* and persons returning to live in Canada, become eligible under the Plan following a waiting period of up to three months. Persons receiving last resort financial assistance are eligible upon registration. Members of the Canadian Forces and RCMP who have not acquired the status of inhabitant of Quebec become eligible the day they arrive, and inmates of federal penitentiaries become eligible the day they are released.

Immediate coverage is provided for certain seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the ministère de l'Éducation [Quebec Department of Education], and refugees. Persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for a period of more than six months become eligible for the plan following a waiting period.

4.0 Portability

4.1 Minimum Waiting Period

Persons settling in Quebec after moving from another province of Canada are entitled to coverage under the Quebec Health Insurance Plan when they cease to be entitled to benefits from their province of origin, provided they register with the Régie.

4.2 Coverage During Temporary Absences Outside Quebec (in Canada)

If living outside Quebec in another province or territory for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec. In the first case, they retain it for four calendar years at most, and in the second, for two consecutive calendar years at most.

This is also the case for persons living in another province or territory who are temporarily employed or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons directly employed or working on contract outside Quebec in another province or territory, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as an inhabitant of the province, provided their families remain in Quebec or they retain a dwelling there.

Status as an inhabitant of the province is also maintained by persons who remain outside the province for 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years and provided they notify the Régie of the absence.

The costs of medical services received in another province or territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the Régie for such services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when the specialized services provided are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 between the Centre de santé Témiscaming (Témiscaming health centre) and North Bay.

Costs of hospital services with which a recipient is provided in another province or territory of Canada are paid in accordance with the terms and conditions of the interprovincial agreement on reciprocal billing regarding hospital insurance agreed on by the provinces and territories of Canada. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or the costs of expensive procedures are paid at approved interprovincial rates. However, since November 1, 1995, the Government of Quebec reimburses a maximum of $450 per day of hospitalization when an Outaouais inhabitant is hospitalized in an Ottawa hospital for non-urgent care or services available in the Outaouais.

Insured persons who leave Quebec to settle in another province or territory of Canada are covered for up to three months after leaving the province.

4.3 Coverage During Temporary Absences Outside Quebec (outside Canada)

Students, unpaid trainees, Quebec government officials posted abroad and employees of non-profit organizations working in international aid or cooperation programs recognized by the Minister of Health and Social Services must contact the Régie to ascertain their eligibility. If the Régie recognizes them as having special status, they receive full reimbursement of hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Persons directly employed or working on contract outside Canada, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as inhabitant of the province, provided their families remain in Quebec or they retain a dwelling there.

As of September 1, 1996, hospital services provided outside Canada in case of emergency or sudden illness are reimbursed by the Régie, usually in Canadian funds, to a maximum of $100 (CDN) per day if the patient was hospitalized (including in the case of day surgery) or to a maximum of $50 (CDN) per day for out-patient services.

However, hemodialysis treatments are covered to a maximum of $220 (CDN) per treatment. In such cases, the Régie provides reimbursement for the associated professional services. The services must be dispensed in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the Régie to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. The cost of all services insured in the province is reimbursed at the Quebec rate, usually in Canadian funds, when they are incurred abroad.

An insured person who moves permanently from Quebec to another country ceases to be a recipient as of the day of departure.

4.4 Prior Approval Requirement

Insured persons requiring medical services in hospitals abroad, in cases where those services are not available in Quebec or elsewhere in Canada, are reimbursed 100 percent if prior consent has been given for medical and hospital services that meet certain conditions. Consent is not given by the Plan's officials if the medical service in question is available in Quebec or elsewhere in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Everyone has the right to receive adequate health care services without any kind of discrimination. There is no extra-billing by Quebec physicians.

5.2 Access to Insured Hospital Services

On March 31, 2007, Quebec had 118 institutions operating as hospital centres for a clientele suffering from acute illnesses. There were 21,400 beds for persons requiring care for acute physical or psychiatric ailments allotted to these institutions. From April 1, 2005 to March 31, 2006, Quebec hospital institutions had nearly 713,732 admissions for short stays (including births) and 302,448 registrations for day surgeries. These hospitalizations accounted for 5,111,799 patient days.

Restructuring of the health network: In November 2003, Quebec announced the implementation of local service networks covering all of Quebec. At the heart of each local network is a new local authority, the Centre de santé et de services sociaux (CSSS) [the health and social services centre]. These centres are the result of the merger of the public institutions whose mission it was to provide CLSC (local community service centre) services, CHSLD (residential and long-term care) services, and, in most cases, neighbourhood hospital services. The CSSSs also provide the people in their territory with access to other medical services, general and specialized hospital services, and social services. To do so, they will have to enter into service agreements with other health sector organizations. The linking of services within a territory forms the local services network. Thus, the aim of integrated local health and social services networks is to make all the stakeholders in a given territory collectively responsible for the health and well-being of the people in that territory.

5.3 Access to Insured Medical and Surgical-Dental Services

Primary care: In 2003–2004, family medicine groups (FMGs) were established. These groups work closely with the CLSCs and other network resources to provide services such as health assessment, case management and follow-up, diagnosis, treatment of acute and chronic problems, and disease prevention. Their services are available 24 hours a day, seven days a week.

In January 2007, Quebec had 121 accredited FMGs. The number of such groups has gone from 21 to 121 in four years.

The Conseil médical du Québec has established a committee to develop the concept of the physician/population ratio because interprovincial comparisons suggest that Quebec has an adequate number of physicians.

5.4 Physician Compensation

Physicians are remunerated in accordance with the negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient according to the fee schedule after the patient has collected from the Régie. Non-participating physicians are paid directly by their patients according to the amount charged.

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient. The Minister may also provide for a different rate of compensation for general practitioners and medical specialists during the first years of practice, depending on the territory or the activity involved. These provisions are preceded by consultation with the organizations representing the professional groups.

While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and non-participating professionals who practice outside the plan, with no reimbursement from the Régie going to either them or their patients.

In 2006–2007, the Régie paid an amount estimated at $3,410,400 to doctors in the province, while the amount for medical services outside the province reached an estimated $9.5 million.

5.5 Payments to Hospitals

The Minister of Health and Social Services funds hospitals through payments directly related to the cost of insured services provided.

The payments made in 2005–2006 to institutions operating as hospital centres for insured health services provided to inhabitants of Quebec were more than $7.8 billion. Payments to hospital centres outside Quebec were approximately $108.2 million.

6.0 Extended Health Care Services

Intermediate care, adult residential care and home care services are available. Admission is coordinated on a regional level and based on a single assessment tool. The CLSCs receive individuals, evaluate their care requirements, and either arrange for provision of services such as day care centre programs or home care, or refer them to the appropriate agencies.

The MSSS offers some home care services, including nursing care and assistance, homemaker services and medical supervision.

Residential facilities and long-term care units in acute-care hospitals focus on maintaining their clients' autonomy and functional abilities by providing them with a variety of programs and services, including health care services.

Ontario

Introduction

Ontario has one of the largest and most complex publicly funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care (MOHLTC), Ontario's health care system was supported by over $35.3 billion (including capital) in spending for 2006–2007.

The Ministry provides services to the public through such programs as health insurance, drug benefits, assistive devices, forensic mental health and supportive housing, long-term care, home care, community and public health, and health promotion and disease prevention. It also regulates hospitals and nursing homes, operates psychiatric hospital and medical laboratories, and co-ordinates emergency health services.

The Ministry established 14 Local Health Integration Networks (LHINs) to plan, integrate and fund health services in their local area for the health service providers. While the LHINs are responsible for managing the local health care system, the Ministry is responsible for establishing overall strategic direction, priorities and outcome measures for the provincial health system.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by Ministry of Health and Long-Term Care (MOHLTC). OHIP is established under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided in hospitals and health facilities, and by physicians and other health care practitioners.

1.2 Reporting Relationship

The *Health Insurance Act* stipulates that the Minister of Health and Long-Term Care is responsible for the administration and operation of OHIP, and is Ontario's public authority for the purposes of the *Canada Health Act* (CHA).

1.3 Audit of Accounts

MOHLTC is audited annually by the Office of the Auditor General of Ontario. The Auditor General's 2006 Annual Report was released on July 23,2007. The Auditor General's 2006 Annual Report on the Ontario Health Insurance Plan was released on December 5, 2006.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2006–2007 Public Accounts of Ontario were released on August 17, 2007.

1.4 Designated Agency

Local Health Integration Networks (LHINs) were established under the *Local Health System Integration Act*, 2006, to improve Ontarians' health through better access to high-quality health services, coordinated health care, and effective and efficient management of the health system at the local level. LHINs are not-for-profit Crown Agencies that plan, integrate and fund local health services that are delivered by hospitals, Community Care Access Centres, long-term care homes, community health centres, community support services, and mental health agencies. The *Local Health System Integration Act* recognizes MOHLTC's obligations under the *French Languages Services Act*, to ensure equitable access to services in French for French-speaking Ontarians.

The *Local Health System Integration Act*, 2006 requires the board of directors of each LHIN to establish, by by-law, the committees of the board that the Minister specifies by regulation. Regulation 417/06, which came into force on September 16, 2006, prescribes two LHIN Board Committees and their responsibilities: an Audit Committee; and, a Community Nominations Committee.

On April 1, 2007, the LHINs assumed full responsibilities for funding, planning, and integrating health care services at the local level.

The Act requires LHINs to prepare an Annual Report for the Minister who is required to table the reports before the Legislative Assembly. The 2006/07 annual reports were received by the Ministry on June 29, 2007, and tabled in the provincial legislature on August 23, 2007.

For fiscal 2007–08, the Ontario Ministry of Health and Long-Term Care will enter into an accountability agreement with each LHIN that will include performance goals and objectives for the networks as well as the allocations for health service providers. The Act also provides the LHINs with the authority to fund health service providers and to enter into service accountability agreements with these providers.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient and out-patient hospital services in Ontario are prescribed under the *Health Insurance Act*, and Regulation 552 under that Act.

Insured in-patient hospital services include medically required: use of operating rooms, obstetrical delivery rooms and anaesthetic facilities; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations; and, accommodation and meals at the standard ward level.

Insured out-patient services include medically required: laboratory, radiological and other diagnostic procedures; use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available; use of diet counselling services; use of the operating room, anesthetic facilities, surgical supplies, necessary nursing service, and supplying of drugs, biologicals, and related preparations (subject to some exceptions), including vaccines, anti-cancer drugs, biologicals and related preparations (subject to some exceptions); provision of equipment, supplies and medication to haemophiliac patients for use at home; and the following drugs for take-home use: cyclosporine to transplant patients; zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection; biosynthetic human growth hormone to patients with endogenous growth hormone deficiency; drugs for treating cystic fibrosis and thalassemia; erythropoeitins to patients with anaemia of end-stage renal disease; alglucerase to patients with Gaucher disease; and clozapine to patients with treatment-resistant schizophrenia.

In 2006–2007, there were 150 public hospital corporations (excluding specialty mental health hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care homes) staffed and in operation in Ontario. This includes 132 acute care hospital corporations, 14 chronic care hospitals, and four general and special rehabilitation units. Though they provide a mix of services, hospitals are categorized by major activity. For example, many acute care hospitals offer chronic care services. A number of designated chronic care facilities also offer rehabilitation.

When insured physician services are provided in licensed facilities outside hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, the Ministry of Health and Long-Term Care (MOHLTC) provides funding through the payment of facility fees under the *Independent Health Facilities Act*. Facility fees cover the cost of the premises, equipment, supplies, and personnel used to render an insured service. Under the *Independent Health Facilities Act*, patient charges for facility fees are prohibited.

Facility fees are charged to the provincial government only by facilities that are licensed under the *Independent Health Facilities Act*. Examples of facilities that are licensed this Act include: surgical/treatment facilities (e.g., those providing abortions, cataract surgery, dialysis and non-cosmetic plastic surgery) and diagnostic facilities (e.g., those providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies). New facilities are ordinarily established through a Request for Proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

Insured physician services are prescribed under the *Health Insurance Act* and regulations under that Act.

Under subsection 37.1(1) of Regulation 552 of the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary; contained in the Schedule of Benefits for Physician Services; and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits. Physicians provide medical, surgical and diagnostic services, including primary health care services. Services are provided in a variety of settings, including: private physician offices, community health centres, hospitals, mental health facilities, licensed independent health facilities, and long-term care homes.

In general terms, insured physician services include: diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anaesthesia; radiology and laboratory services in approved facilities; and, immunizations, injections and tests.

The Schedule of Benefits is regularly reviewed and revised to reflect current medical practice and new technologies. New services may be added, existing services revised or obsolete services removed through regulatory amendment. This process involves consultation with the Ontario Medical Association.

During 2006–2007, physicians could submit claims for all insured services rendered to insured persons directly to the Ontario Health Insurance Plan (OHIP) office, in accordance with section 15 of the *Health Insurance Act*, or a limited number could bill the insured person, as specified in section 15 of the Act (see also Part II of the *Commitment to the Future of Medicare Act*). Physicians who do not bill OHIP directly are commonly referred to as having "opted-out". When a physician has opted out, the physician bills the patient (not exceeding the amount payable for the service under the Schedule of Benefits), and the patient is then entitled to re-imbursement by OHIP. However, the number of physicians who may opt out was fixed (on a "grandparented" basis) following proclamation of the *Commitment to the Future of Medicare Act* on September 23, 2004.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario.

There were approximately 23,000 physicians who submitted claims to OHIP in 2006–2007.

2.3 Insured Surgical-Dental Services

Certain surgical-dental services are prescribed as insured services in section 16 of Regulation 552 in the *Health Insurance Act* and the Dental Schedule of Benefits. The *Health Insurance Act* authorizes OHIP to cover a limited number of procedures when the insured services are medically necessary and are performed in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D by a dental surgeon who has been appointed to the dental staff of the public hospital.

Approximately 315 dentists and dental/oral surgeons provided insured surgical-dental services in Ontario in 2006–2007.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services prescribed by and rendered in accordance with the *Health Insurance Act* and regulations under that Act are insured.

Uninsured hospital services include: additional charges for preferred accommodation unless prescribed by a physician, oral-maxillofacial surgeon or midwife; telephones and televisions; charges for private-duty nursing; provision of medications for patients to take home from hospital, with certain exceptions; and in-province, out-patient hospital visits solely for administering drugs, subject to certain exceptions.

Section 24 of Regulation 552 details those physician services that are specifically prescribed as uninsured.

Uninsured physician services include: services that are not medically necessary; toll charges for long-distance telephone calls; the preparation or provision of a drug, antigen, antiserum or other substance, unless the drug, antigen or antiserum is used to facilitate a procedure; advice given by telephone at the request of the insured person or the person's representative; an interview or case conference (in limited circumstances); the preparation and transfer of records at the insured person's request; a service that is received wholly or partly for producing or completing a document or transmitting information to a "third party" in prescribed circumstances; the production or completion of a document or transmitting information to any person other than the insured person in prescribed circumstances; provision of a prescription when no concomitant insured service is rendered; acupuncture procedures; psychological testing; and, research and experimental survey programs.

3.0 Universality

3.1 Eligibility

To be considered a resident of Ontario for the purpose of obtaining Ontario health insurance coverage, a person must:

- hold Canadian citizenship or an immigration status as prescribed in Regulation 552 of the *Health Insurance Act*;
- make his or her permanent and principal home in Ontario;
- be physically present in Ontario for at least 153 days in any 12-month period; and
- in most cases, Ministry of Health and Long-Term Care (MOHLTC) policy requires new and returning residents applying for health coverage to be physically present in Ontario for 153 of the first 183 days following the date residency is established in Ontario (i.e., a person cannot be away from the province for more than 30 days in the first six months of residency).

With certain exceptions in which there is an exemption from the waiting period, residents of Ontario, as defined in Regulation 552 of the

Health Insurance Act, are eligible for Ontario health insurance coverage subject to a three-month waiting period. MOHLTC assesses whether or not an individual is subject to the three-month waiting period at the time of their application for health coverage. Examples of those who are exempt from the three-month waiting period include newborn babies born in Ontario and insured residents from another province or territory who move to Ontario and immediately become residents of approved charitable homes, homes for the aged or nursing homes in Ontario.

In July 2006, MOHLTC amended section 3(4) of Regulation 552 of the *Health Insurance Act* to exempt Canadian citizens and Permanent Residents/Landed Immigrants from the three-month waiting period for Ontario Health Insurance Plan (OHIP) coverage, if they arrive in Ontario after July 20, 2006, from a foreign country where an evacuation effort is being undertaken or facilitated by the federal government.

Individuals who are not eligible for OHIP coverage are those who do not meet the definition of a resident, including those who do not hold an immigration status that is set out in Regulation 552, such as tourists, transients, and visitors to the province. Other individuals such as federal penitentiary inmates, Canadian Forces and ranked Royal Canadian Mounted Police personnel do not require Ontario health insurance coverage as their health services are covered under a federal health care plan.

Persons who were previously ineligible for Ontario health insurance coverage but whose status and/or residency situation has changed (e.g., change in immigration status) may be eligible, upon application, subject to the requirements of Regulation 552.

When MOHLTC determines that a person is not eligible or is no longer eligible for OHIP coverage, a request may be made to MOHLTC to review the decision. Anyone may request that MOHLTC review the denial of their OHIP eligibility by making a request in writing to the General Manager of OHIP.

3.2 Registration Requirements

Every resident of Ontario (or their legally authorized substitute decision maker) who seeks Ontario health insurance coverage, is required to apply to MOHLTC.

A health card is issued to eligible residents upon applying to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing their permanent and principal home in the province. Registration is done through local OHIP offices. Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide MOHLTC with original documents to prove their Canadian citizenship or eligible immigration status, their residency in Ontario and their identity. Eligible applicants over the age of 15.5 are generally required to have their photographs and signatures captured for their photo health cards.

Each photo health card has a renewal/expiry date in the bottom right-hand corner of the card. MOHLTC mails renewal notices to registrants several weeks before the card's renewal date.

MOHLTC is the sole payer for OHIP insured physician, hospital, and dental surgical services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for the cost of any insured service that is covered by OHIP (with the exception of during a waiting period).

Approximately 12.6 million Ontario residents were registered with OHIP and held valid and active health cards as of as of April 1, 2007.

3.3 Other Categories of Individual

MOHLTC provides health insurance coverage to residents of Ontario other than Canadian citizens and Permanent Residents/Landed Immigrants. These residents are required to provide acceptable documentation to support their eligible immigration status, their residency in Ontario, and their identity in the same manner as Canadian citizen or Permanent Resident/Landed Immigrant applicants.

The individuals listed below, who ordinarily reside in Ontario, may be eligible for Ontario health insurance coverage in accordance with Regulation 552 and prevailing MOHLTC policy. Clients applying for coverage under any of these categories should contact their local OHIP office for further details.

Applicants for Permanent Residence/Applicants for Landing: These are persons who have submitted an application for Permanent Resident/Landed Immigrant status to Citizenship and Immigration Canada (CIC) and have passed CIC's medical requirements.

Convention Refugees and Protected Persons: These are persons who are determined to be Convention Refugees or Protected Persons under the terms of the *Immigration and Refugee Protection Act.* Members of this group are exempt from the three-month waiting period.

Holders of Temporary Resident Permits/Minister's Permits: A Temporary Resident Permit/Minister's Permit is issued to an individual by Citi-zenship and Immigration Canada when there are compelling reasons to admit an individual into Canada who would otherwise be inadmissible under the federal *Immigration and Refugee Protection Act.* Each Temporary Resident Permit/Minister's Permit has a case type, or numerical designation, on the permit that indicates the circumstances allowing the individual entry into Canada. Only individuals who hold a Temporary Resident Permit/Minister's Permit with a case type of 80 (except adoption), 81, 84, 85, 90, 91, 92, 93, 94, 95 and 96 are not eligible for Ontario health insurance coverage.

Clergy, Foreign Workers and their Accompanying Family Members: An eligible foreign clergy is a person who is sponsored by a religious organization or denomination and has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer located in Ontario, and has been issued a Work Permit/Employment Authorization by CIC that names the Canadian employer, states the person's prospective occupation, and has been issued for a period of at least six months.

Spouses, same sex partners and/or dependant children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker are also eligible for Ontario health insurance coverage if the member of the clergy or the foreign worker is to be employed in Ontario for at least three consecutive years and if the family member will be ordinarily a resident of Ontario.

Live-in Caregivers: Eligible Live-in Caregivers are persons who hold a valid Work Permit/ Employment Authorization under the Live-in Caregivers in Canada Program (LCP) or the former Foreign Domestic Movement (FDM) administered by CIC, and ordinarily resides in Ontario. The Work Permit/Employment Authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers.

Migrant Farm Workers: Migrant farm workers are persons who have been issued a Work Permit/ Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by CIC. Due to the special nature of their employment, migrant farm workers are exempt from the three-month waiting period and are not required to be ordinarily resident in Ontario (may be resident for less than the required five month period and not have a permanent and principal home in Ontario) and still qualify for OHIP.

3.4 Premiums

There are no premiums payable as a condition of obtaining Ontario health insurance coverage. The Ontario Health Premium is collected through the provincial income tax system and is not connected to OHIP registration or eligibility in any way. Responsibility for the administration of the Ontario Health Premium lies with the Ontario Ministry of Finance.

4.0 Portability

4.1 Minimum Waiting Period

In accordance with subsection 3(3) of Regulation 552 under the *Health Insurance Act*, individuals who move to Ontario are typically entitled to Ontario Health Insurance Plan (OHIP) coverage, three months after establishing residency in the province, unless listed as an exception in section 3(4).

In accordance with Ministry of Health and Long-Term Care (MOHLTC) policy, persons moving permanently to Ontario from another Canadian province or territory will typically be eligible for OHIP coverage on the first day of the third month following the date residency is established.

4.2 Coverage During Temporary Absences in Canada

Insured out-of-province services are prescribed under sections 28, 29 to 32 of Regulation 552 of the *Health Insurance Act*.

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability; therefore, insured residents who are temporarily outside of Ontario could use their Ontario health cards to obtain insured health services.

An insured person who leaves Ontario temporarily to travel within Canada, without establishing residency in another province or territory, may continue to be covered by OHIP for a period of up to 12 months.

An insured person who seeks or accepts employment in another province or territory may continue to be covered by OHIP for a period of up to 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, may be eligible for continuous health insurance coverage for the duration of their full-time studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide MOHLTC with documentation from their educational institution confirming registration as a full-time student. Family members (spouses and dependent children) of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

In accordance with MOHLTC policy, most insured residents who want to travel, work or study outside Ontario, but within Canada, must have resided in Ontario for at least 153 days in the last 12-month period immediately prior to departure from Ontario.

Ontario participates in the Hospital Reciprocal billing agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Interprovincial Health Insurance Agreements Coordinating Committee.

Ontario also participates in the physicians' reciprocal billing arrangements with all other provinces and territories, except Québec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services. Ontario residents who may be required to pay for physician services received in Québec can submit their receipts to MOHLTC for payment as an insured service at Ontario rates.

4.3 Coverage During Temporary Absences Outside Canada

Health insurance coverage for insured Ontario residents during extended absences outside Canada is governed by sections 28.1 through 29 (inclusive) and section 31 of Regulation 552 of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1(4), 1.1(5) and 1.1(6) of Regulation 552 of the *Health Insurance Act*, MOHLTC may provide insured Ontario residents with continuous Ontario health insurance coverage during absences outside Canada of longer than 212 days (seven months) in a 12-month period.

The Ministry requests that residents apply to MOHLTC for this coverage before their departure and provide documents explaining the reason for their absence outside Canada. In accordance with the regulations and MOHLTC policy, most applicants must also have been present in Ontario for at least 153 days in each of the two consecutive 12-month periods before their expected date of departure.

The length of time that MOHLTC will provide a person with continuous Ontario health coverage during an extended absence outside Canada varies depending on the reason for the absence. Please refer to the information below for further details:

Reason	OHIP Coverage
Study	Duration of a full-time accredited academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/Other	Up to two years in a lifetime

Certain family members may also qualify for continuous Ontario health coverage while accompanying the primary applicant on an extended absence outside Canada and should contact their local OHIP office for details.

Out-of-country services are covered under sections 28.1 to 28.6 inclusive, and sections 29 and 31 of Regulation 552 of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- a maximum $400 (CDN) for in-patient services;
- a maximum $50 (CDN) for out-patient services (except dialysis); and
- the actual cost incurred by the patient per dialysis treatment.

During 2006–2007, emergency medically necessary out-of-country physician and other eligible practitioner services were reimbursed at the Ontario rates detailed in regulation under the *Health Insurance Act* or the amount billed, whichever is less. Charges for medically necessary emergency or out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed or approved hospital or a licensed health facility. Medically necessary out-of-country laboratory services when done on an emergency basis by a physician are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less, and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

In 2006–2007, Ontario's payments for out-of-country emergency in-patient and out-patient insured hospital and medical services amounted to $25.0 million.

4.4 Prior Approval Requirement

As set out in section 28.4 of Regulation 552 of the *Health Insurance Act*, prior approval from MOHLTC is required for payment for non-emergent health services provided outside of Canada. Where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or cause irreversible tissue damage, the patient may be entitled to full funding for out-of-country health services.

Under section 28.5 of Regulation 552 of the *Health Insurance Act*, laboratory tests performed outside Canada are paid for, with prior approval from MOHLTC, if the following conditions are met:

- the kind of service or test is not performed in Ontario;
- the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person;
- the service or test is not experimental; and
- the service or test is not performed for research purposes.

In 2006–2007, Ontario's total payments for prior-approved treatment outside Canada were $70.1 million.

There is no formal prior-approval process required for services provided to Ontario residents outside the province, except within Canada if the insured service is covered under the Hospital Reciprocal Billing System. All uninsured or approved for clinical usage (experimental) devices and drugs are the costs of the patient and must have prior approval from their home province. As detailed above in section 4.2, the Interprovincial Agreement on Eligibility and Portability ensures that Ontario residents who are temporarily travelling, working or studying in another province continue to be eligible for Ontario health coverage.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, physician and surgical-dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and physician services, as defined in the *Health Insurance Act*.

Accessibility to insured health care services is protected under the *Commitment to the Future of Medicare Act* (CFMA). This Act prohibits any person or any entity from charging more or accepting payment or other benefit for more than the amount payable by the Ontario Health Insurance Plan (OHIP). In addition, the CFMA also prohibits physicians, practitioners and hospitals from refusing to provide an insured service if an insured person chooses not to pay for an uninsured service. The Act further prohibits any person or entity from paying, conferring or receiving any benefit in exchange for preferred access to an insured service.

The Ministry of Health and Long-Term Care (MOHLTC) investigates all possible contraventions of Part II of the CFMA that come to its attention. For situations in which it is found that a patient has made an unauthorized payment, the Ministry ensures that the amount is repaid to that patient.

MOHLTC implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to MOHLTC a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

Public hospitals in Ontario are not permitted to refuse the provision of services in life-threatening situations because the person is not insured.

In 2006–2007, there were 151 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 6,781,528 acute patient days, 1,944,159 chronic patient days and 770,450 rehabilitation patient days delivered by public hospitals.

Acute care priority services are designated highly specialized hospital-based services that deal with life-threatening conditions. These services are often high-cost and rapidly growing, which has made access a concern. Generally, these services are managed provincially, on a time-limited basis.

Acute care Priority services include:

- selected cardiovascular services;
- selected cancer services;
- chronic kidney disease;
- critical care services; and
- organ and tissue donation and organ transplantation.

5.3 Access to Insured Physician and Dental-Surgical Services

Initiatives

- Underserviced Area Program (UAP): UAP is one of a number of supports that MOHLTC provides to help communities across the province access needed health care services. UAP provides a variety of integrated initiatives aimed at attracting and retaining health care providers. To be eligible for the UAP's recruitment and retention benefits, a community must be designated as underserviced. UAP works closely with underserviced communities to identify their need for health human resources. It provides financial incentives and practice supports, and enables community access to primary care services in smaller, rural areas unable to support full-time family physicians by providing funding to operate 21 nursing stations, as well as access to physician services by funding locums and outreach clinics in northern communities experiencing physician shortages. Currently, there are 141 communities in Ontario designated as underserviced for general/family practitioners and 14 northern Ontario communities designated as underserviced for medical specialists.
- Northern Physician Retention Initiative (NPRI): NPRI provides eligible family practitioners and specialists who maintain practices in northern Ontario for at least four years with a retention incentive as well as access to funding for continuing medical education.
- Northern Health Travel Grant Program (NHTG): NHTG helps defray transportation costs for residents of northern Ontario who must travel long distances to access insured hospital and specialist medical services that are not locally available, and also promotes using specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.
- Primary Health Care: During 2006–2007, Ontario continued to align its new and existing primary care delivery models to help improve and expand access to primary health care for all Ontarians by continuing to include elements such as after-hours access to telephone triage, health information, and on-call physicians (as required) through the Telephone Health Advisory Service (THAS), increased after-hours coverage and preventive care initiatives that enhance health promotion, disease prevention, and chronic disease management. As of March 31, 2007,

there were approximately 7.4 million patients rostered to physicians in the primary care models that have these features. The Rural & Northern Physician Group Agreement (RNPGA) has been implemented in 39 northern Ontario communities since April 2004. In 2007, eight additional rural northern communities have been identified as eligible for the agreement, while 14 southern communities are identified as eligible for a modified version of the agreement. There are negotiated agreements in place to address other special needs populations such as: the homeless, remote First Nations communities, palliative care patients, and maternity centre patients. Another model is currently being developed to recognize and compensate physicians for the uniqueness of practicing within speciality areas such as HIV, oncology, and care of the elderly. As part of transforming its health care system, Ontario has approved 150 family health teams since April 2005, with all expected to be operational by 2007/08, thereby improving access for more than 2.5 million Ontario residents in 112 communities.

- The 2004 Memorandum of Agreement between MOHLTC and the Ontario Medical Association provides for the alignment of the Primary Care Network (PCN) and Health Service Organization (HSO) models into one model—the Family Health Organization (FHO). In May 2007, the FHO model was offered to all family physicians in Ontario.

5.4 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Some physician payments are provided through fee-for-service arrangements. Remuneration is based on the Schedule of Benefits under the *Health Insurance Act*. Other physician payment models include Alternate Payment Plans and new funding arrangements for physicians in Academic Health Science Centres.

General practitioners paid solely on a fee-for-service basis represent 39 per cent of Ontario's registered general practitioners. The remaining family physicians in Ontario receive funding through one of the primary care initiatives such as Family Health Organizations, Family Health Networks, Family Health Groups, Comprehensive Care Models, and Family Health Teams. Family Health Teams build upon existing primary care physician funded models by providing funding for inter-disciplinary health care professionals, who work as integral members of the team. Physicians participating in Family Health Teams are funded by one of three compensation options that include: Blended Capitation (such as FHN/FHO), Complement Based Models (RNPGA or other specialized model agreements) and Blended Salary Model (for community or mixed governed FHTs).

MOHLTC negotiates payment rates and other changes to the Schedule of Benefits for Physician Services with the Ontario Medical Association. A new Physician Services' Agreement with the Ontario Medical Association was negotiated for a four-year term, from April 2004 to March 2008. The Agreement provided for an across-the-board fee increase of 2 per cent for specialists and 2.5 per cent for general practitioners/family physicians, effective April 1, 2004. Further increases in specific fee codes are scheduled for implementation on various dates from October 1, 2005, through to January 1, 2008.

The Agreement eliminated payment thresholds effective April 1, 2005. This Agreement expands access to care in rural communities by introducing new funding to support hospital-based specialists in the north; enhances care for seniors by introducing new on-call fees in long-term care homes, home care and palliative care; supports hospital care by expanding hospital on-call coverage and in-hospital care fees for specialists and by introducing new fees for family doctors caring for their own patients in emergency departments; supports health promotion and disease prevention by introducing special fees for managing specific chronic diseases; invests in initiatives to recruit physicians to Ontario; and, makes quality of life improvements for physicians such as expanding pregnancy and parental leave benefits.

Under the Agreement, the parties began meeting in April 2007, to undertake a performance review of the degree to which the objectives under the Agreement have been met.

With respect to insured surgical-dental services, MOHLTC negotiates changes to the Schedule of Benefits for Dental Services with the Ontario Dental Association. In 2002–2003, MOHLTC and the Ontario Dental Association agreed on a new multi-year funding agreement for dental services, which became effective on April 1, 2003, and expired on March 31, 2007. The terms of the agreement continue until a new contract is negotiated by the parties.

5.5 Payments to Hospitals

The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority services, wait time strategies, and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

Transfer payments to hospitals are based on historical global allocations and multi-year incremental increases that incorporate population growth and anticipated service demands within the available provincial budget.

Each year, public hospitals submit Hospital Annual Planning Submissions that are the result of broad consultations within the facilities (e.g., all levels of staff, unions, physicians and board) and within the community and region. Hospital Annual Planning Submissions are based on a multi-year budget and provide a corresponding multi-year planning forecast. The data submitted in the Hospital Annual Planning Submissions is used to populate schedules for service volumes and performance targets that form the contractual basis for the Hospital Accountability Agreement.

In the Hospital Accountability Agreement, hospital performance is measured through five key performance indicators: total margin, current ratio, percentage of full-time nurses, relative risk of readmission and chronic care patient quality indicators. A review of the targets in each of the schedules and a discussion of corresponding corridors for performance indicators in the Hospital Accountability Agreement are conducted between Ministry staff and hospitals.

The Interprovincial Hospitals' Reciprocal billing agreements are a convenient administrative arrangement in which provincial/territorial governments reimburse hospitals for insured services from other provinces/territories.

On April 1 2007, Local Health Integration Networks (LHINs) assumed funding authority for hospitals in Ontario. The LHINs are leading the negotiations of the Hospital Service Accountability Agreements and the Hospital Annual Planning Submission process.

MOHLTC reviews chronic care co-payment regulations and rates annually, accounting for changes in the Consumer Price Index and Old Age Security each year, and determines whether revisions to the regulations and rates are appropriate.

6.0 Recognition

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health Transfer in its 2006–2007 publications.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

Long-Term Care (LTC) homes provide care and personal support services and accommodation for people who are no longer able to live independently. Nursing care is available on-site 24-hours a day. Residents may also require on-site supervision, personal care and monitoring to ensure their safety and well-being. The home-like environment is intended to foster the best possible quality of life. The Ministry of Health and Long-Term Care (MOHLTC) currently funds and regulates all LTC homes licensed or approved under three different Acts: the *Homes for the Aged and Rest Homes Act*, the *Nursing Homes Act*, and the *Charitable Institutions Act*.

The new *Long-Term Care Homes Act*, 2007, which received Royal Assent on June 4, 2007, replaces the three existing pieces of legislation and provides a legislative framework to enable improved management of and quality of services to, a growing and rapidly changing sector. Regulations to support the implementation of the new Act are under development. The new Act will also enable better planning for the needs of the population requiring appropriate residential services provided in a LTC home.

As of April 30, 2007, there were approximately 608 LTC homes with 75,302 beds including 256 not-for-profit (including municipal, charitable and not-for–profit nursing homes) and 352 for-profit homes.

Long-Term Care homes offer higher levels of nursing and personal care support services than those offered by either retirement homes or supportive housing. Residents in LTC homes must qualify for placement in the homes. Placement is solely coordinated by Community Care Access Centres (CCACs). Retirement homes are neither regulated nor funded by the Ministry.

MOHLTC regulates the Long-Term Care home sector through its Compliance Management Program which is designed to safeguard residents' rights, safety, security, quality of care and quality of life. Through the Compliance Management Program, MOHLTC monitors and inspects LTC homes for compliance with legislation, regulation, standards and criteria, service agreements and, where necessary, uses enforcement measures to achieve compliance.

On August 1, 2005, new regulations were introduced to ensure that at least one registered nurse is on site and on duty in all LTC homes 24 hours a day, seven days a week.

Effective January 1, 2006, all LTC homes were required to implement two new standards: Skin Care and Wound Management, and Continence Care. As of April 1, 2006, Ministry Compliance Advisors began monitoring compliance with the new standards.

The Ministry's public Reports on Long-Term Care Homes website provides information on all LTC homes in Ontario, including reports on home profiles, the outcomes of compliance inspections and verified complaint inspections for a 12-month period.

Through the 2007/08 budget, $57.7 million in annualized funding was approved to create 1,200 new Registered Practical Nurse (RPN) positions to enhance care in Long-Term Care homes.

7.2 Home Care Services

Ontario home and community care programs provide a range of services that support people living in their homes or other community care settings. These services are available through Community Care Access Centres (CCACs) and Community Service agencies.

CCACs provide simplified access for eligible Ontario residents, of all ages, to home and community care; coordinate the delivery of home care services to people in their homes, schools and communities; and, authorize admission to long-term care homes. There is no charge for services provided by CCACs.

The CCAC is responsible for the following:

- Providing or purchasing a range of community services on behalf of eligible clients. The range of services includes: nursing, homemaking, personal support, physiotherapy, occupational therapy, speech-language pathology, social work, dietetics, medical supplies and dressings, hospital and sickroom equipment, assistance in obtaining a drug card and laboratory and diagnostic services, and transportation to medical appointments and hospitals;
- Assessing an individual's requirements and determining their eligibility for professional health services, homemaking, and personal support services provided in people's homes and in the community. CCACs assess and determine eligibility for professional health and personal support services for children/youth in schools and receiving home schooling;
- Developing plans of service;
- Providing information and referral services for the public to home and community care related services;
- Managing admission to LTC homes; and
- Managing the Requests for Proposal process for purchased client services.

Legislation most relevant to CCACs includes: the *Long-Term Care Act*, 1994; *Health Insurance Act*; *Community Care Access Corporations Act*, 2001; *Nursing Homes Act*; *Charitable Institutions Act*; *Homes for the Aged and Rest Homes Act*; *Local Health System Integration Act*, 2006; and *French Language Services Act*. Each CCAC must also be familiar with all other relevant laws, including but not limited to the *Health Care Consent Act*, 1996; *Substitute Decisions Act*, 1992; *Personal Health Information Protection Act*, 2004; and the *Ministry of Health Appeal and Review Boards Act*, 1998.

Community service agencies provide support services that include: respite, volunteer hospice services, services for persons with physical disabilities, Alzheimer services, homemaking, attendant care, adult day services, caregiver support, meal services, home maintenance and repair, friendly visiting, security checks and reassurance, social and recreational services, volunteer transportation, palliative care consultation and education, and services for persons with physical disabilities such as attendant outreach, direct funding and special services for the blind and hearing impaired. Some of these community services are also provided to clients through assisted living services in supportive housing and there are services specifically for clients with acquired brain injury. Community services are legislated under the *Long-Term Care Act*, 1994 and are delivered by community-based, not-for-profit agencies that rely heavily on volunteers, and are funded by MOHLTC.

The provincial End-of-Life Care Strategy helps replace hospitalizations, where appropriate, with home care services made possible through advances in treatment practices, collaborative planning between all health care sectors, and increased resources. The objectives of the strategy are to shift care of the dying from the acute setting to an appropriate alternate setting based on individual preference; to enhance/develop a client-centred and interdisciplinary end-of-life care service capacity; and to improve access to, and coordination/consistency of comprehensive end-of-life care services. End-of-Life care services are provided in home or the community by CCACs, Community Support Service agencies and residential hospices.

7.3 Ambulatory Health Care Services

Community Health Centres are transfer payment agencies governed by incorporated non-profit community boards of directors that include members of the community served by the centre. The name

"Community Health Centre" reflects the fact that the agency is established by the community and provides programs and services in response to needs identified in that community. Community Health Centres deliver services through inter-disciplinary teams including physicians, nurse practitioners, nurses, counsellors, dieticians, therapists, community health workers and health promoters. Services include comprehensive primary care as well as group and community programs, such as diabetes education, parent/child programs, community kitchens, and youth outreach services. Community Health Centres work within a population health framework that places an equal emphasis on providing comprehensive primary care, preventing illness, and health promotion.

Community Health Centres identify the priority populations that they will serve—traditionally people have experienced barriers to access based on culture, language, literacy, age, geographic isolation, socio-economic status, disability, mental health status and homelessness. Community Health Centres also develop partnerships with other service providers to improve access to care, promote effective service integration and build community capacity to address the social determinants of health in their communities.

Service is provided through 54 Community Health Centres operating from more than 80 full-service sites across Ontario. Of these, 27 are in large urban centres, 14 are in smaller urban centres, and 13 are in either northern or rural communities. There is no legislation specific to Community Health Centres.

Historically, Community Health Centres have been developed based on expressions of interest from sponsoring groups. This has resulted in an uneven distribution and some significant gaps in coverage across the province. Between 2004–2008, the government is expanding the network of Community Health Centres by adding 22 new centres and 27 satellite centres. This expansion will be targeted to communities with at-risk populations facing barriers to access. Once implemented, it is expected that many of the most critical gaps in coverage will be addressed.

Registered Persons	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	12,100,000	12,200,000	12,400,000	12,500,000 [1]	12,600,000 [1]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	139	135	135	134	132
b. chronic care	11	13	13	14	14
c. rehabilitative care	4	4	4	4	4
d. other	3	3	3	4	4
e. total	157 [2]	155 [2]	155 [2]	156 [2]	154 [2]
3. Payments for insured health services ($):					
a. acute care	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
b. chronic care	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
c. rehabilitative care	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
d. other	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
e. total	10,300,000,000	10,300,000,000	12,300,000,000	12,700,000,000	13,500,000,000
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
b. diagnostic imaging facilities	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
c. total	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
b. diagnostic imaging facilities	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
c. total	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]

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1. These estimates represent the number of Valid and Active Health Cards (have current eligibility and resident has incurred a claims in the last 7 years).
2. Provincial Psychiatric Hospitals are excluded and Specialty Mental Health Hospitals are reported under 2(d) — Other.
3. Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed. Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.
4. Data are not collected in a single system in MOHLTC. Further, the MOHLTC is unable to categorize providers/facilities as "for-profit" as MOHLTC does not have financial statements detailing service providers' disbursement of revenues from the ministry."

Insured Hospital Services Provided to Residents in Another Province or Territory	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	9,306	9,023	8,184	8,374	8,037
7. Total payments, in-patient ($).	48,500,000	63,000,000	52,000,000	54,000,000	49,870,000
8. Total number of claims, out-patient (#).	140,692	167,143	154,460	174,848	139,036
9. Total payments, out-patient ($).	16,500,000	20,000,000	23,000,000	29,100,000	25,576,000
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	23,295	21,458	21,710	23,845	20,800
11. Total payments, in-patient ($).	27,200,000	32,000,000	42,466,826	66,916,271	76,828,432
12. Total number of claims, out-patient (#).	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
13. Total payments, out-patient ($).	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]

Insured Physician Services Within Own Province or Territory	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	10,508	10,611	10,660	10,774	11,114
b. specialists	10,724	10,703	11,016	11,460	12,087
c. other	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
d. total	21,232	21,314	21,676	22,234	23,201
15. Number of opted-out physicians (#):					
a. general practitioners	17	15	14	12	13
b. specialists	134	114	62	39	36
c. other	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
d. total	151	129	76	51	49
16. Number of not participating physicians (#):					
a. general practitioners	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
b. specialists	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
c. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
d. total	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	188,309,344 [9]	192,572,601 [9]	200,825,265 [9]	215,980,656 [9]	222,632,480 [9]
b. total payments ($)	5,420,010,700 [9]	5,945,003,300 [9]	6,424,329,400 [9]	7,072,813,000 [9]	7,791,581,966 [9]
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	179,100,000	182,000,000	191,451,200	203,656,000	204,545,656
b. total payments ($)	4,798,300,000	4,973,000,000	5,312,085,618	5,642,049,000	5,962,775,787

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[5] Included in #24.

[6] Included in #26.

[7] All physicians are categorized as general practitioner or specialist.

[8] Ontario has no non-participating physicians, only opted-out physicians who are reported under item #8.

[9] Number of services includes services provided by Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, and Academic Health Science Centres. Total Payments includes payments made to Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, and Academic Health Science Centres and the Hospital On Call Program. Services and payments related to Other Practitioner Programs, Out-of-Country/Out-of-Province Programs, and Community Labs are excluded.

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
19. Number of services (#).	497,880	557,720	534,179	573,830	627,375
20. Total payments ($).	17,700,000	18,600,000	20,300,000	21,164,600	23,754,500
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	200,428	180,395	179,410	200,723	182,693
22. Total payments ($).	10,200,000	9,900,000	11,635,998	13,211,381	19,351,944

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
23. Number of participating dentists (#).	319	323	335	330	316
24. Number of services provided (#).	75,600	72,900	86,000	87,111	92,264
25. Total payments ($).	9,300,000	9,200,000	11,786,600	12,546,397	14,229,896

Manitoba

Introduction

Manitoba Health and Healthy Living provides leadership and support to protect, promote and preserve the health of all Manitobans. The Department is organized into five distinct but related functional areas: Corporate and Provincial Program Support; Healthy Living and Health Programs; Health Workforce; Regional Affairs and Administration; Finance and Accountability. Their mandates are derived from established legislation and policy pertaining to health and wellness issues. The roles and responsibilities of the Department include policy, program and standards development, fiscal and program accountability and evaluation.

Manitoba Health and Healthy Living remains committed to sustaining our universal, comprehensive and accessible health care system and improving the health status of all Manitobans. In support of these commitments, a number of activities were initiated in 2006/07.

The Ministry of Healthy Living continued to lead and shape the department's focus on promoting healthful practices and preventing disease and injury through the launch of the Healthy Eating Campaign—a province-wide initiative to promote healthy eating and good nutrition in our schools and additional resources to support the Healthy Aging Strategy to promote healthy living among older adults.

Manitoba introduced a $155 million Five Point Plan to improve access to quality care and reduce wait times in the five federal priority areas, as well as four additional Manitoba areas. The Plan involves more diagnostic testing, more surgeries, more health professionals, system innovation and better wait time management, prevention and health promotion.

Manitoba has embarked on major provincial quality improvement endeavours that include a mandatory reporting and learning process which is aimed at enhancing patient safety by reducing the potential for recurrence of critical incidents. This move from a voluntary, less comprehensive process signals a commitment from policy-makers for substantial improvements to safety with adverse events being addressed systemically within the healthcare system. With regard to this commitment, The *Regional Health Authorities Act* and The *Manitoba Evidence Amendment Act* were proclaimed November 1, 2006. Regions are now operationalizing legislative requirements including specific critical incident reporting and investigation requirement processes and procedures.

The Manitoba Institute for Patient Safety (MIPS), established in 2004, continues to implement a variety of activities to promote, coordinate and stimulate research and initiatives that enhance patient safety and quality care. These included their health literacy initiative, *It's Safe to Ask*, introduced in several loca-tions in Manitoba in late 2006. This initiative consists of practical tools for both patients and health care providers. The aim of this initiative is to enhance clear communication and help reduce health care errors and critical clinical occurrences. *It's Safe to Ask* will lead to stronger communication between patients and providers, leading patients to become more informed about their health and more active in their healthcare. MIPS continues to facilitate culture of safety surveys in the regions, steer the Manitoba Node for the Safer Healthcare Now! Campaign and Chair the Annual Provincial Patient Safety Workshops and other professional and public forums.

In 2006/07, Manitoba Health and Healthy Living continued the restructuring of Provincial Drug Programs to establish three functional units—Operational Program Management, Professional Services and Drug Management Policy—to facilitate comprehensive, coordinated and proactive drug benefit program management for the publicly-funded drug programs in Manitoba. The Operational Program Management Unit is responsible for operational issues. The Professional Services Unit focuses on formulary management and implementation of drug management intervention strategies. The Drug Management Policy Unit provides for focused policy and planning capacity on emerging drug management and utilization issues. Specifically, the Drug Management Policy Unit develops and leads the implementation of policies and strategies to increase drug supply chain efficiencies and to enhance prescribing practices and drug utilization to maximize health outcomes; develops drug benefit plan design enhancements to manage pharmaceutical expenditures; and develops capacity and implements cost effective communication strategies aimed at, firstly, transferring knowledge and increasing awareness among prescribers, providers, and patients about appropriate drug use and, secondly, facilitating consultation and dialogue with stakeholders.

A new Long Term Care Seniors' Strategy based on the principle of Aging in Place will increase community living support and provide alternatives to institutional care. By increasing the opportunity to remain in one's community, or "age in place," Manitobans will be provided options to continue to contribute to the social, civic and economic life of the community.

Significant capital investments were also made in acute care facilities: the Cardiac Care Centre at St. Boniface General Hospital, the Critical Services Redevelopment Project at Health Sciences Centre (HSC), the Burn Unit project at HSC, the Mature Women's Program (relocation and expansion of this program from HSC to Victoria General Hospital), the new Reproductive Health Centre (Women's Health Clinics Satellite), the new Misericordia Isolation Room, The Winnipeg Regional Health Authority (WRHA) Laundry Department upgrade and establishment of a Community Cancer Program.

In addition, significant capital investments included two long term care facilities: an addition to and renovation of a new 39 bed unit at Foyer Valade Personal Care Home in Winnipeg; and a new 35 bed Personal Care Home, Northern Spirit Manor, located in Thompson, Manitoba.

Further provincial program capital investments included: the Brandon Regional Health Centre Medical Transportation Coordination Centre; the Primary Health Care Transcona Access Centre providing significant tenant improvements, expansions and/or upgrades to the Swan Valley Health Centre and the St. Anne and Flin Flon Hospitals; a new Health Care Centre in Wabowden; and enhancement of rehabilitation services with the initiation of the WRHA Rehabilitation Reconfiguration Project.

The introduction of a new province-wide program to enhance screening for colorectal cancer in targeted age groups was announced in January 2007. The Colorectal Cancer Screening Program project, phase 1 of a provincial program, was approved to begin April 1, 2007. This project will occur in three stages over a 2.5 year period to project completion in October, 2008/09, for the targeted population of select individuals aged 50–74 years old in Manitoba who reside in the Assiniboine and Winnipeg Regional Health Authorities. A total of 25,000 individuals with an equal combination of rural and urban residents will be invited to participate.

The Role and Mission of Manitoba Health and Healthy Living

The Department of Health (Manitoba Health and Healthy Living) is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Ministers of Health and Healthy Living. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for planning and delivering services.

Manitoba Health and Health Living's vision is healthy Manitobans through an appropriate balance of prevention and care.

It is the mission of Manitoba Health and Healthy Living to lead a publicly administered sustainable health system that meets the needs of Manitobans and promotes their health and well-being. This is accomplished through a structure of comprehensive envelopes encompassing program, policy and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments on behalf of Manitobans for insured health benefits related to the costs of medical, hospital, personal care, pharmacare and other health services.

It is also the role of Manitoba Health and Healthy Living to foster innovation in the health care system. This is accomplished by developing mechanisms to assess and monitor quality of care, utilization and cost-effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems and alternative, less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under The *Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act[1] was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to Manitoba Health and Healthy Living. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical and other health services referred to in acts of the Legislature or regulations there under. The Act was amended on January 1, 1999, to provide insurance for out-patient services relating to insured medical services provided in surgical facilities.

The Minister of Health is responsible for administering and operating the Plan. Under section 3(2), the Minister has the power:

- to provide insurance for residents of the province in respect of the costs of hospital services, medical services and other health services, and personal care;
- to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
- to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements that the Minister considers necessary to ensure that adequate standards are maintained;

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[1] Where reference is made to "the Act" in the text, this refers to the *Health Services Insurance Act* as consolidated to March 31, 2007.

- to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the Minister considers necessary to ensure that such a consulting service is provided;
- to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals, which are required by the Government of Canada, are submitted; and
- in cases where residents do not have available medical services and other health services, to take such measures that are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents.

The Minister may also enter into contracts and agreements with any person or group that he or she considers necessary for the purposes of the Act. The Minister may also make grants to any person or group for the purposes of the Act on such terms and conditions that are considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the regulations.

There were no legislative amendments to the Act or the regulations in the 2006–2007 fiscal year that affected the public administration of the Plan.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to prepare an annual report, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it, if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the Act requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the Plan annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2006–2007 fiscal year and is contained in the Manitoba Health and Healthy Living Annual Report, 2006–2007. It will also be available on the Province's website in late October 2007.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Sections 46 and 47 of the Act, as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93), provide for insured hospital services.

As of March 31, 2007, there were 97 facilities providing insured hospital services to both in- and out-patients. Hospitals are designated by the Hospitals Designation Regulation (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in- and out-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologics and related preparations; routine medical and surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

All hospital services are added to the list of available hospital services through the health planning process.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health and Healthy Living is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (M.R. 49/93) made under the Act.

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, and be registered and licensed under the *Medical Act.* As of March 31, 2007, there were 2,244 physicians on the Manitoba Health and Healthy Living Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with section 91 of the Act and section 5 of the Medical Services Insurance Regulation. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or regulations. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health and Healthy Living is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services that are not excluded under the Excluded Services Regulation (M.R. 46/93) of the Act, rendered to an insured person by a physician.

During fiscal year 2006–2007, a number of new insured services were added to a revised fee schedule. The Physician's Manual can be viewed on-line at:

http://www.gov.mb.ca/health/manual/index.html

In order for a physician's service to be added to the list of those covered by Manitoba Health and Healthy Living, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The MMA will negotiate the item, including the fee, with Manitoba Health and Healthy Living. Manitoba Health and Healthy Living may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93) under the Act. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist. As of March 31, 2007, 590 dentists were registered with Manitoba Health and Healthy Living.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to or collect from an insured person a fee in excess of the benefits payable under the Act or regulations. No providers of dental services had opted out as of March 31, 2007.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA will negotiate the fee with Manitoba Health and Healthy Living.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The Excluded Services Regulation (M.R. 46/93) made under the Act sets out those services that are not insured. These include: examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties; group immunization or other group services except where authorized by Manitoba Health and Healthy Living; services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants; preparation of records, reports, certificates, communications and testimony in court; mileage or travelling time; services provided by psychologists, chiropodists and other practitioners not provided for in the legislation; in vitro fertilization; tattoo removal; contact lens fitting; reversal of sterilization procedures; and psychoanalysis.

The Hospital Services Insurance and Administration Regulation states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

Manitoba Health is continuing to address the issue of patient charges for medical supplies, or "tray fees" and remains committed to taking the necessary steps to prevent this practice.

All Manitoba residents have equal access to services. Third parties such as private insurers or the Workers Compensation Board do not receive priority access to services through additional payment. Manitoba has no formalized process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows Regional Health Authorities and Manitoba Health and Healthy Living to monitor usage and service concerns.

To de-insure services covered by Manitoba Health and Healthy Living, the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health and Healthy Living in 2006–2007.

3.0 Universality

3.1 Eligibility

The *Health Services Insurance Act* defines the eligibility of Manitoba residents for coverage under the provincial health care insurance plan. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, makes his or her home in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a temporary resident permit under the *Immigration and Refugee Protection Act* (Canada), unless the Minister determines otherwise, or is a visitor, transient or tourist.

The Residency and Registration Regulation (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have a work permit of 12 months or more.

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

> " A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival. "

There are currently no other waiting periods in Manitoba.

The MHSIP excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Royal Canadian Mounted Police Act*; *Veteran's Rehabilitation Act*; or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The excluded are residents who are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP) and federal inmates. These residents become eligible for Manitoba Health and Healthy Living coverage upon discharge from the Canadian Forces, the RCMP, or if an inmate of a penitentiary has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health and Healthy Living (Residency and Registration Regulation (M.R. 54/93, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health and Healthy Living that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health and Healthy Living will provide a registration card for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health and Healthy Living to pay for all medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for payment of all hospital services and for the provincial drug program.

As of March 31, 2007, there were 1,188,209 residents registered with the health care insurance plan.

There is no provision for a resident to opt out of the Manitoba Health and Healthy Living Plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit issued by Citizenship and Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health and Healthy Living coverage.

As of March 31, 2007, there were 6,692 individuals on work permits covered under the MHSIP.

The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada). No legislative amendments to the Act or the regulations in the 2006–2007 fiscal year affected universality.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation (M.R. 54/93, section 6) identifies the waiting period for insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arriving in Manitoba is entitled to benefits on the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation (M.R. 54/93 section 7(1)) defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient, high-cost procedures and out-patient services are based on national rates agreed to by provincial or territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 2006–2007, Manitoba Health and Healthy Living made payments of approximately $26.7 million for hospital services and $9.9 million for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation (M.R. 54/93, sub-section 7(1)) defines the rules for portability of health insurance during temporary absences from Canada.

Residents on full-time employment contracts outside Canada will receive Manitoba Health and Healthy Living coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health and Healthy Living for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health and Healthy Living for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba after completing their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93). Hospital services received outside Canada due to an emergency or a sudden illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per-diem rate according to hospital size:

- 1–100 beds: $280
- 101–500 beds: $365
- over 500 beds: $570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health and Healthy Living with a recommendation from a specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at the equivalent Manitoba rate for similar services. Hospital services are paid at a minimum of 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15–23).

Manitoba Health and Healthy Living made payments of approximately $3,834,000 for hospital care provided in hospitals outside Canada in the 2006–2007 fiscal year. In addition, Manitoba Health and Healthy Living made payments of approximately $1,118,800 for medical care outside Canada.

In instances where Manitoba Health and Healthy Living has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health and Healthy Living will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval by Manitoba Health and Healthy Living is not required for services provided in other provinces or territories or for emergency care provided outside Canada. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health and Healthy Living to receive approval for coverage.

No legislative amendments to the Act or the regulations in the 2006–2007 fiscal year had an effect on portability.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health and Healthy Living ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Surgical Facilities Regulation (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

In July 2001, the *Health Services Insurance Act*, the *Private Hospitals Act* and the *Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

- changes to definitions and other provisions to ensure that no charges can be made to individuals who receive insured surgical services or to anyone else on that person's behalf; and
- ensuring that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

On February 10, 2004, Manitoba officially opened the expanded Health Links/Info Santé, a 35-seat, state-of-the-art call centre with a call capacity of 300,000 per year.

Manitobans now have access to vital health information and assistance in 120 languages 24-hours a day, seven days a week.

Public demand for Health Links/Info Santé has increased steadily since it began as a six station call back service in 1994. Manitobans value the service. Providing this information source relieves pressure on other areas of the health care system, particularly emergency rooms.

Through the Primary Health Care Transition Fund, multi-jurisdictional envelope funds have been made available to implement a program to manage patients with congestive heart failure. Beginning in November 2004, this 17-month initiative will evaluate the benefits of using health lines to manage patients with chronic diseases.

5.2 Access to Insured Hospital Services

All Manitobans have access to hospital services including acute care, psychiatric extended treatment, mental health, palliative, chronic, long-term assessment/rehabilitation and to personal care facilities. There has been a shift in focus from hospital beds to community services, out-patients and day surgeries, which are also insured services.

Manitoba's nursing supply has improved significantly in Winnipeg, with a more gradual improvement noted in rural and northern regions. The increased supply of nurses is primarily due to an investment in nursing education. Enrolment in nursing education programs continues to be fully subscribed. The Nurses Recruitment and Retention Fund (NRRF) has also contributed significantly to improving nursing supply in Manitoba through initiatives such as relocation assistance, funding for continuing education for nurses and special project grants, and the Conditional Grant Program to encourage new graduates to work in rural and northern regions (outside Winnipeg and Brandon). In June 2005, the Extended Practice Regulation came to effect to allow nurses on the register to independently prescribe drugs, order screening and diagnostic tests, and perform minor surgical and invasive procedures as set out in regulation.

In addition, Manitoba has a wide range of other health care professionals. Significant shortages in midwifery are being addressed through a new degree program - student enrolment is fully subscribed—and through partnership with other jurisdictions on the development of a bridging program for midwifery. Shortages in some of the technology fields persist, primarily in rural and northern areas of the Province. Shortages in some of the technology fields such as medical radiology technology, medical laboratory technology and sonography continue to be an issue; however recent expansions of training opportunities are expected to have positive impacts in the near future.

Manitoba currently has access to six Magnetic Resonance Imaging (MRI) machines for clinical testing. The first unit was installed in 1990 by the St. Boniface Research Foundation. In Winnipeg, there are three MRI machines located at St. Boniface General Hospital, and two located at the Health Sciences Centre. One of the MRIs at the Health Science Centre was a joint initiative with the National Research Council (NRC). The sixth MRI was opened at Brandon Regional Health Centre in June 2004. This was the first MRI machine to be located outside Winnipeg. The seventh and newest MRI opened at Pan AM Clinic and became operational November 21, 2005.

Manitoba has 19 Computerized Tomography (CT) scanners, 11 in Winnipeg, 8 in rural Manitoba and one in CancerCare Manitoba. In Winnipeg there are three (one for paediatric patients) at the Health Sciences Centre, two at the St. Boniface General Hospital, one each at Victoria General Hospital, Misericordia Health Centre, Seven Oaks, Grace and Concordia Hospitals. The rural CT scanners are located throughout the province, in Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Bethesda Hospital, The Pas Hospital and Selkirk Regional Health Centre. As well, Portage District General Hospital has purchased a new scanner and Brandon has replaced a 64 slice scanner. Dauphin has also replaced a 16 slice CT scanner.

There are a total of 93 diagnostic ultrasound scanners in Manitoba. Sixty-nine are in Winnipeg health facilities and 24 are in located the rural and northern Regional Health Authorities.

In January 2007, the 15th Community Cancer Program (CCP) became operational in Pinawa.

CCPs are oncology out-patient units within rural acute-care hospitals that are developed under the direction and support of CancerCare Manitoba. The CCPs deliver a variety of treatments including chemotherapy for most cancer diagnoses, as well as supportive and follow-up care, and strive to minimize the need for patients to travel to Winnipeg. Services are delivered by health professionals specially trained in oncology and include the preparation and administration of chemotherapy.

The Manitoba Prostate Cancer Centre became operational in October 2004. It is located on the third floor of the new CancerCare building at 675 McDermot Avenue. The Prostate Centre includes a wide variety of services for Manitoba men including clinical assessment, information to help with patient decision-making, linkages with prostate cancer support groups and research conducted in the area of prostate disease.

In October 2006, the last of seven cytology laboratories of the laboratory network and laboratory quality assurance program for the central and confidential Cervical Cancer Screening Registry began submitting results electronically. The follow-up function of the Registry implements follow-up with Health Care Providers for any Pap test with a high grade abnormal result and no follow-up Colposcopy visit within three months of the test, and provides directions for updating Registry records. The Manitoba Breast Cancer Screening Program has a mandate to ensure that the women in Manitoba aged 18 to 69 years receive organized, high quality cervical cancer screening services.

Wait time funding has provided for additional hip and knee joint replacements at several sites in Winnipeg, Brandon Regional Health Centre and Boundary Trails Health Centre. Prehabilitation clinics have also been established in Winnipeg, Brandon and Boundary Trails to optimize patient health prior to their joint replacement surgery, resulting in better health outcomes.

A central provincial registry was established in 2006 for all lower extremity joint replacement surgery.

The Pan Am Clinic, formed in 1979, has evolved from a sports medicine clinic into a comprehensive musculo-skeletal specialty centre. The Pan Am Clinic came under the ownership of the Winnipeg Regional Health Authority (WRHA) on September 1, 2001. In March 2006, a minor injury clinic for kids was opened in conjunction with the WRHA Child Health Program.

Consolidation of the Cardiac Surgery Program to St. Boniface General Hospital occurred on January 15, 2007, as planned in response to the comprehensive external review of the entire cardiac program in 2003.

Additional cataract procedures to reduce wait lists have been added at Pan Am Clinic in Winnipeg and at Brandon Regional Health Centre.

In March 2005, the expansion of paediatric dental surgery services to Misericordia Health Centre (MHC) was initiated to reduce waiting times. Further, 200 surgeries were added to Thompson General Hospital at the beginning of August 2005, and an additional 200 annual surgeries at the Maples Surgical Centre beginning in January 2007.

The WRHA Emergency Care Task Force was initiated in January 2004 and concluded its work in January 2006. During its two years of work, a total of 46 recommendations for short and long term improvements in emergency care in Winnipeg hospitals were identified and plans for implementation defined. While some recommendations have been fully implemented, work continues on others as many recommendations involve system issues. Highlights include enhanced diagnostic capabilities, enhanced education for Emergency Department staff, redevelopment of physical space and improved IT support.

In response to the ongoing challenges with delivery of Emergency Medical Services and the recognition that system-based solutions would most effectively address these challenges, Manitoba Health and

Healthy Living, in conjunction with the Regional Health Authorities and Emergency Department physicians, conducted a review of Emergency Department service across the province. The review was completed in November 2006. As a result, both short and medium to long-term strategies to enact system changes were developed. Strategies include (but are not limited to) the provision of enhanced physician education opportunities in the specialty and the development of system supports for Emergency Departments including diagnostics, mental health and allied health.

The Wait Times Task Force was established in 2006 to improve access to quality care and reduce wait times. The Wait-Time Reduction Strategy targets the five priority areas identified by First Ministers in their 10-year plan to strengthen health care: cancer, cardiac, diagnostic imaging, joint replacement and sight restoration. In addition, Manitoba is targeting four other priority areas: children's dental surgeries, mental health programs, pain management and treatment for sleep disorders.

In January 2007, a satellite pain clinic was opened at the Pan Am Clinic in Winnipeg to address the needs/wait times in pain management services.

Manitoba Health and Healthy Living announced a plan in February 2007 to provide increased access to sleep disorder testing and treatment through a centralized intake and referral process, and the expansion of the sleep testing program.

A plan was developed in consultation with practitioners and stakeholders, which will increase the number of surgeries and procedures, invest in human resources, technology and capital, and provide regional health authorities with new wait-list management tools and resources.

The Wait Time Task Force established the Manitoba Patient Access Network which is charged with developing new approaches to patient navigation through better system integration and coordination, improving patient access to services, and ensuring sustainability of initiatives.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2006–2007, Manitoba Health and Healthy Living continued to support initiatives to improve access to physicians in rural and northern areas of the province. One of the supported initiatives, implemented in the fall of 2005, was a co-ordinated process to assist Regional Health Authorities with the logistics of recruiting foreign-trained physicians. The co-ordinated process, administered through the Physician Resource Coordination Office (PRCO), is aimed at avoiding duplication of effort, while introducing future physician candidates to opportunities available in Manitoba.

The province supports many initiatives aimed at recruiting and retaining physicians. There are initiatives that facilitate the entry of eligible foreign medical graduates into the physician workforce; one that provides training leading to licensure, and one that provides assessment leading to licensure. Through the training program, foreign-trained physicians can achieve conditional licensure to practice family medicine in return for agreeing to work in a sponsoring rural Regional Health Authority. Eligible applicants may enter one year of residency training similar to family medicine residency training and upon successful completion of that training may be granted conditional licensure for primary care practice in a rural or northern community of Manitoba. The new assessment leading to licensure was introduced in the Fall of 2006. Eligible applicants undergo a pre-employment interview, an orientation, a three day Family Practice Assessment and a three month Clinical Field Assessment. Upon successful completion of the assessment, candidates may be recommended for conditional licensure and upon commencement of practice are linked with a physician mentor for a minimum of 12 months. Another initiative assists in facilitating the assessment of physicians whose practice will be limited to a specialty field of training. Through this program clinical assessments are organized and facilitated in order for foreign trained physicians to meet the College of Physicians and Surgeons of Manitoba (CPSM) criteria for licensure.

Manitoba continues to experience increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province continued to provide a financial assistance grant, introduced in 2001, for students and residents. In return for financial assistance during their training, the student or resident agrees to work in Manitoba for a specific period after graduating. In 2005 the Practice Assistance Option of the Medical Student/Resident Financial Assistance Program was enhanced to provide two grants of $50,000 each to physicians re-entering training in an area of critical need in the Province, such as emergency medicine or anaesthesia. In addition five grants of $15,000 each have been made available to Family Physicians who have been working in an urban area and five grants of $25,000 each to Family Physicians working in a rural/northern area of the Province, subject to certain eligibility criteria. Since 2001, Manitoba has supported an expansion in medical school class sizes, which continues in 2006 with the first year enrolment for the fall of this year reaching 101 students.

The Manitoba Telehealth Network under the leadership of the Winnipeg Regional Health Authority has implemented the infrastructure to link 23 Telehealth sites across the province. This modern telecommunications link means patients can be seen by specialists and medical staff can consult with each other without having to endure the expense and inconvenience of travelling from the north to Winnipeg. In September 2002, Manitoba Health and Healthy Living launched the new Manitoba Telehealth site at St. Boniface General Hospital, officially linking its medical specialists to patients and colleagues province-wide.

5.4 Physician/Dentist Compensation

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, salaried, sessional and blended.

The *Health Services Insurance Act* governs payment to physicians for insured services. There were no amendments to the *Health Services Insurance Act* (HSIA) related to physician compensation during the 2006–2007 fiscal year.

Fee-for-service remains the dominant method of payment for physician services. Notwithstanding, alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive either a salary (employer-employee relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods to "top-up" the wages of physicians whose fee-for-service income may not be competitive, yet whose services remain vital to the province. As well, physicians may receive sessional payments for providing medical services, as well as stipends for on-call responsibilities.

Representatives from the Manitoba Medical Association (MMA) and Manitoba Health and Healthy Living typically negotiate compensation agreements for physicians.

The June 27, 2005, settlement, effective April 1, 2005 to March 31, 2008, maintained the terms of the June 2, 2002, Arbitration Agreement(subsequently entrenched in the 2003–2005 MMA-Manitoba Heath and Healthy Living Agreement), including:

- the continuation of a Physician Retention Fund ($5 million per annum over the duration of this agreement as well as the subsequent agreement);
- the continuation of the Professional Liability Insurance Fund ($5 million per annum for 2006 through to 2011);

- the continuation of the Continuing Medical Education Fund ($2 million per annum from 2006 through 2011);
- the continuation of a Maternity/Parental Benefits Fund ($1 million per annum from 2005 through to 2011);
- a mechanism to initiate arbitration proceedings with respect to a subsequent agreement, if notice is given by either party by January 1, 2007;
- that physicians covered by the Agreement shall refrain from stopping work or curtailing services and to continue to provide services without interruption; and
- continuation of the Grievance Arbitration procedure set forth in the March 8, 1994, Fee-For-Service Agreement between the parties.

The highlights of the June 27, 2005, Negotiated Settlement include:

- a three-year term from April 1, 2005 to March 31, 2008;
- an overall increase of 7.5 percent (non-compounded) to the Fee-For-Service Schedule of Benefits, as well as alternate-funded agreements and arrangements);
    - 2.5 percent effective April 1, 2005
    - 2.5 percent effective April 1, 2006
    - 2.5 percent effective April 1, 2007
- an additional $10 million was applied to the schedule of benefits through a Shoring Up Fund and an additional $5.5 million was applied to outstanding fee-for-service issues through the Exceptional Issues Fund;
- an additional $5 million was applied to alternate funding contracts though the Alternate Funding Shoring Up Fund;
- an extension of maternity and parental benefits to all Manitoba physicians, including interns and residents continued;
- increased incentives for family doctors to provide full-service care and to maintain hospital privileges; and,
- increases to the rates for physicians under alternate funding agreements in the amount of 2.5 percent effective April 1, 2005; 2.5 percent effective April 1, 2006; and 2.5 percent effective April 1, 2007 (non-compounded); were also applied over and above the fee-for-service increase.

5.5 Payments to Hospitals

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operational agreements between Regional Health Authorities and the operators of hospitals and personal care homes, defined as "health corporations" under the Act.

Pursuant to the provisions of this division, Authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that enables the health services to be provided by the health corporation, the funding to be provided by the Authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request that the Minister of Health appoint a mediator to help them resolve outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute. The Minister's resolution is binding on the parties.

There are three Regional Health Authorities which have hospitals operated by health corporations in their health regions. The Regional Health Authorities have concluded the required agreements with health corporations. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities. In all other regions, the hospitals are operated by the *Regional*

Health Authorities Act. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

The allocation of resources by Regional Health Authorities for providing hospital services is approved by Manitoba Health and Healthy Living through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act.* Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act,* payments from the MHSIP for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the regulations in 2006–2007 had an effect on payments to hospitals.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health Transfer (CHT) in public documents. Federal transfers are identified in the Estimates of Expenditures and Revenue (Manitoba Budget) document and in the Public Accounts of Manitoba. Both documents are published annually by the Manitoba government. In addition, the Department of Health and Healthy Living of Manitoba cites the federal contribution from the First Ministers Ten Year Plan to Strengthen Health Care (the 2004 Health Accord—Wait Time Reduction Fund) in funding letters to the Regional Health Authorities and other organizations who are implementing programs using this funding.

7.0 Extended Health Care Services

Manitoba has established community-based service programs as appropriate alternatives to hospital services. These service programs are funded by Manitoba Health and Healthy Living through the Regional Health Authorities. The services include the following:

Personal Care Home Services: Insured personal care services are provided pursuant to the Personal Care Services Insurance and Administration Regulation under the *Health Services Insurance Act.* In 2005, the Personal Care Homes Standards Regulation and Personal Care Homes Licensing Regulation were enacted under the same Act, linking licensing to compliance with a range of standards designed to ensure safe, quality care. Both proprietary and non-proprietary homes are licensed by Manitoba Health and Healthy Living. Personal care homes are visited every 2 years to review progress in meeting personal care home standards. Residents of personal care homes pay a residential charge towards accommodation costs, with the cost of care funded by Manitoba Health and Healthy Living through the Regional Health Authorities. Total Manitoba Health and Healthy Living operating funding during the fiscal year 2006–07 was $450,638,599. This funding supported the delivery of insured personal care services in a total of 9,832 personal care home beds plus a total of 177 chronic care beds, 30 palliative care beds, and 149 rehabilitation beds. A 35 bed personal care home servicing the north opened with 5 beds designated for behavioural management of adult brain injuries. In addition, Manitoba Health and Healthy Living provided $26,284,000 in capital funding for approved capital projects and safety and security upgrades.

Home Care Services: The Manitoba Home Care Program is the oldest comprehensive, province-wide, universal home care program in Canada. Manitoba Home Care provides effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home Care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. Home Care case co-coordinators conduct assessments and develop individual care plans, which may include self or family Managed Care, personal care assistance, household maintenance, professional health care, in-home family relief, facility-based respite care, some supplies and equipment, access to adult day programs, and/or access to support services to seniors' programs that coordinate volunteers, congregate meal programs, transportation, emergency response systems and other activities that support continued independent community living.

Mental Health and Addictions Services: Regional Health Authorities provide in-patient, out-patient and community mental health services. The exception to this is that Manitoba Health and Healthy Living funds and provides mental health self-help and the provincial mental health centre. Community Mental Health Workers provide assessment, service planning, short-term counselling interventions, rehabilitation and recovery planning, crisis intervention, community consultation and in some cases education. Some regions have a variety of intensive and supportive programs such as Intensive Case Management, Supported Employment, Supported Housing and, the Program for Assertive Community Treatment teams and the Early Psychosis Prevention and Intervention Service.

Addictions services and supports are provided through provincially funded agencies. They include the Addictions Foundation of Manitoba (AFM), The Behavioural Health Foundation, Salvation Army—Anchorage, Native Addictions Council of Manitoba, Tamarack, Laurel Centre, Esther House, Addictions Recovery Inc., Youth Centralized Intake, Youth Stabilization and outreach. These agencies work to reduce the harm associated with alcohol and other drugs. Programs include education, prevention, rehabilitation and follow-up supports such as second-stage housing. In addition to the provincially funded agencies, the Winnipeg Regional Health Authority funds two detox programs and the Norman Regional Health Authority funds a residential treatment agency for adults.

Primary Health Care:

One of Manitoba Health's strategic priorities is the need to address primary care renewal. The goals for the upcoming years are:

- improved access to primary care services,
- development of multidisciplinary collaborative teams,
- establishment of improved linkages amongst the different levels of care,
- skill building in the areas of quality improvement/ leadership,
- access to and use of information systems,
- improved working environment for all primary care providers, and
- demonstration of high quality care with a specific focus on chronic disease management.

In order to fulfill these goals, work was accomplished in the following areas:

Two awareness workshops on Advanced Access were held to acquaint primary care physicians and their staff with Advanced Access and its benefits. The response was significant with the majority of the participants willing to learn more. Plans are underway to work with committed clinics in the implementation and spread of Advanced Access within the province.

Two Physician Manager Institutes (PMI), developed and sponsored by the Canadian Medical Association, were hosted by the Primary Health Care Branch and each were attended by approximately 40 physicians.

The Primary Health Care Transition Fund provided many lessons for the development and effective functioning of inter-disciplinary teams. The need to ensure that practitioners are prepared and ready to work in teams is essential. Facilitation workshops were held with regional personnel to give team managers the skills and tools to facilitate the development of high performance teams. A blueprint or framework to look at a province wide implementation of interprofessional collaborative teams is underway.

The Primary Care Information Systems Steering Committee was struck to provide guidance for practitioners choosing Primary Care systems, remove roadblocks to adoption of Primary Care systems, and reduce the cost and improve the management of Primary Care System/EHR inter-operability. Work is ongoing.

Another key strategy includes the development of Physician Integrated Network (PIN) which has been evolving under the guidance of an Advisory Committee with representation from the University of Manitoba; the Colleges of Registered Nurses and Physicians & Surgeons of Manitoba; the Manitoba Medical Association; the Winnipeg and Assiniboine Regional Health Authorities and other primary care stakeholders.

The Physician Integrated Network initiative focuses on the engagement of fee-for-service physician groups. The objectives of this initiative are to improve access to primary care, to improve primary care providers' access to and use of information systems, to improve the working environment for all primary care providers, and to demonstrate high quality care with a specific focus on chronic disease management.

Through the PIN initiative three clinics—Agassiz (Morden), Wiebe (Winkler) and Assiniboine (Winnipeg)—have been identified as demonstration sites to implement practice changes and are remunerated based on quality targets. One clinic (Steinbach) will provide data on the same quality indicators, as a control site.

All four clinics already have EMR systems. However, system and usage changes are necessary to provide the required data. Each clinic is expected to provide information management deliverables, which include: detailed indicator definitions, extract file specifications, report specifications, tested extract and report, data entry procedures, training.

One unique component of the PIN initiative is the development of Quality Based Incentive Funding (QBIF). The purpose behind QBIF was the desire of family physicians and funders to stabilize funding while also supporting quality primary care. PIN is addressing this through the exploration of blended funding (FFS combined with QBIF). PIN QBIF funding is linked to performance on selected clinical process indicators.

An additional initiative to support primary care renewal is supporting the integration of nurse practitioners into primary care in order to improve access to primary care services and to support the implementation of multidisciplinary teams. The Registered Nurse (Extended Practice) Regulation was enacted in 2005, and 32 were registered by the end of 2006. Most work in primary care settings. An RN(EP) is a registered nurse with additional education in health assessment, diagnosis and management of illnesses and injuries. In addition to the services a registered nurse can already provide, an RN(EP) can prescribe medications, order and manage the results of diagnostic and screening tests and perform minor surgical and invasive procedures. Manitoba Health and Healthy Living is working with the Regional Health Authorities to develop new RN(EP) positions, provide a bursary for nurse practitioner study and to provide supports for successful integration of this new practitioner.

Manitoba introduced regulated and funded midwifery services in 2000. Midwives provide primary care for women and newborns, including well-woman care. The province provides funding for midwifery services to 6 of 11 Regional Health Authorities. Just over half of midwifery services are provided outside the Winnipeg Region; including rural, northern and remote communities. In some rural and northern communities, midwives provide care for up to 30% of births; provincially for 5% of births. Homebirth services are provided for 20% of midwifery clients; 1% of provincial births. Service is focused on priority populations, representing over 65% of midwifery clients; including those at high social risk such as substance abusers. The program provides comprehensive, community-based care, and has significantly lower rates of pre-term birth, high and low birth weights. Significant human resource needs in midwifery are being addressed by a new Bachelor of Midwifery (Aboriginal Midwifery) program through University College of the North, and participation with other jurisdictions in development of a bridging program for internationally educated midwives.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).[2]	1,156,217	1,159,784	1,169,667	1,173,815	1,178,457

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	92	92	98[3]	98[3]	95[3]
b. chronic care	5	5	3[4]	3[4]	2[4]
c. rehabilitative care	not available	not available	not available	not available	2[4]
d. other	not available	not available	not available	not available	1[5]
e. total	97	97	98	98	97
3. Payments for insured health services ($):					
a. acute care	1,148,652,940	1,220,253,362	1,400,448,441	1,488,094,835	1,515,237,203
b. chronic care	107,840,132	117,642,127	96,364,992	71,117,677	75,250,507
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	not available	1,252,657	1,290,989	1,305,132	1,292,830
b. diagnostic imaging facilities	0	0	0	0	0
c. total	not available	1,252,657	1,290,989	1,305,132	1,292,830

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	2,714	2,928	3,036	2,995	2,806
7. Total payments, in-patient ($).	12,918,117	16,290,426	15,393,378	19,153,208	19,431,036
8. Total number of claims, out-patient (#).	26,059	31,100	24,057	29,685	30,357
9. Total payments, out-patient ($).	3,783,059	4,369,889	3,896,789	5,670,133	6,306,240
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	569	418	540	569	589
11. Total payments, in-patient ($).	1,847,910	1,348,148	1,085,650	1,455,908	1,294,963
12. Total number of claims, out-patient (#).	6,025	6,069	6,170	6,690	7,673
13. Total payments, out-patient ($).	914,251	1,216,073	1,112,466	1,325,062	1,695,844

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[2] The population data is based on records of residents registered with Manitoba Health as of June 1.

[3] 95 submitting Acute facilities includes 22 Nursing Stations and 2 Federal Hospitals

[4] One Acute facility has been given a rehab institution submitting number: Riverview Health Centre. Deer Lodge is no longer a submitting acute care facility, and therefore only counted as rehab and chronic.

[5] Manitoba Adolescent Treatment Centre

Insured Physician Services Within Own Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
14. Number of participating physicians (#):					
a. general practitioners	954	959	979	981	971
b. specialists	1,010	980	1,008	1,035	997
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,964	1,939	1,987	2,016	1,968
15. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	0
b. specialists	not applicable	not applicable	not applicable	not applicable	0
c. other	not applicable	not applicable	not applicable	not applicable	0
d. total	not applicable	not applicable	not applicable	not applicable	0
16. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	521,611,200	559,271,513	601,240,469	653,290,519	700,465,401
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	15,940,720	16,268,844	16,578,401	17,466,368	16,794,320
b. total payments ($)	365,794,499	384,547,781	415,749,772	442,485,124	438,813,332

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
19. Number of services (#).	212,795	210,294	209,152	228,090	248,900
20. Total payments ($).	7,691,159	7,579,028	8,109,229	8,966,703	9,997,409
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	5,826	5,324	5,714	6,136	6,486
22. Total payments ($).	607,066	519,782	426,937	608,524	541,403

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
23. Number of participating dentists (#).	116	102	114	115	122
24. Number of services provided (#).	3,455	3,498	3,774	3,863	4,205
25. Total payments ($).	714,590	750,122	875,657	936,091	984,621

Saskatchewan

Introduction

In 2006–07, The Action Plan for Saskatchewan Health Care continued to guide the work of Saskatchewan Health. Saskatchewan is committed to strengthening its health care system, retaining and recruiting health care providers, providing timely access to quality services and planning for sustainability of a system that continues to face increasing demands for services.

The Action Plan provides a clear picture of the government's health care priorities and plans and is available to the public at:

www.health.gov.sk.ca

The following examples highlight key actions that were accomplished by Saskatchewan Health during the 2006–07 year.

Infrastructure projects such as the planning for the Muskeg Lake Cree Nation Diabetes Centre and the new Saskatchewan Disease Control Laboratory at the Regina Research Park are underway. In addition the Cypress Regional Hospital, a new 89-bed regional hospital in Swift Current was completed in April 2007. Construction continued on the Ile a la Crosse joint use facility, providing 11 inpatient rooms, 17 long-term care rooms, community and public services, as well as a share of community spaces attached to a high school and day care.

Saskatchewan Health worked with its many partners to develop a plan for children's mental health services in Saskatchewan, as recommended by the Children's Advocate. Several initiatives under the plan were accomplished including:

- the development and distribution of a booklet on depression and suicide in youth, and a brochure about the children's mental health services plan;
- filling positions such as the psychologist position for distance specialist consultation for southern Saskatchewan, the social work/psychology positions (3) for family-based therapeutic residential services for youth with mental disorders in Moose Jaw, Prince Albert and Lloydminster, and the social work position to provide children's mental health services in the Melfort, Nipawin, Tisdale region; and
- additional mental health outreach and respite services are being provided.

Substance abuse prevention and treatment options for youth and families continue to be addressed. *The Youth Drug Detoxification and Stabilization Act* was proclaimed on April 1, 2006. Six interim beds were opened at the Secure Youth Detoxification Centre in Regina; youth outreach and associated services related to the Act are being implemented in each of the 12 regional health authorities and the Athabasca Health Authority; and mobile treatment is being delivered in northern Saskatchewan communities.

Saskatchewan Health continues to put emphasis on reducing wait times for diagnostic and surgery services and on ensuring the best possible patient outcomes are achieved.

A new radiology information system and picture archiving communication system will securely schedule, store and quickly transmit digital images between health facilities, enabling authorized care givers to view and/or consult on studies without having to transport patients. The systems will reduce costs and delays for patients and the health system. The Saskatoon and Regina Qu'Appelle Regional Health Authorities will be the first to implement the Radiology Information System, followed by mid-sized regions.

Between March 31, 2006 and March 31, 2007, the number of patients waiting for surgery in

Saskatchewan's seven largest regional health authorities decreased by more than 2,600, and the number on the registry who have been waiting longer than a year for their surgery decreased by more than 1,200.

Working Together: Saskatchewan's Health Workforce Action Plan, released in December 2005, set out a plan to improve health care in Saskatchewan by keeping and attracting health care professionals. Recruitment and retention of our healthcare professionals remains a top priority. A $25 million retention and recruitment fund was put in place in September 2006 - a three-year initiative to retain and recruit health professionals in Saskatchewan. The Health Workforce Steering Committee and a Provincial Nursing Committee were formed to advise on the development, implementation and evaluation of recruitment and retention initiatives. Included under this fund is a $6 million relocation and recruitment grant program to encourage health providers to move to Saskatchewan and work in rural, northern and hard-to-recruit positions, as well as a $6 million retention grant program for retention projects focused on keeping health providers in Saskatchewan. In addition, Saskatchewan Health developed and launched a provincial recruitment agency and website:

www.HealthCareersinSask.ca.

Saskatchewan Health has a mandate to support Saskatchewan residents in achieving their best possible health and well-being. It carries out this mandate by establishing policy direction, setting and monitoring standards, providing funding, supporting regional health authorities, and ensuring the provision of essential and appropriate services to Saskatchewan residents.

In 2006–07, the government budgeted $3.189 billion for health care. This represents an increase of 10.2 per cent or $295.6 million over the previous year.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of *The Department of Health Act* authorizes that the Minister of Health may:

- pay part of, or the whole of, the cost of providing health services for any persons or classes of person who may be designated by the Lieutenant Governor in Council;
- make grants or loans or provide subsidies to regional health authorities, health care organizations or municipalities for providing and operating health services or public health services;
- pay part of or the whole of the cost of providing health services in any health region or part of a health region in which those services are considered by the Minister to be required;
- make grants or provide subsidies to any health agency that the Minister considers necessary; and
- make grants or provide subsidies to stimulate and develop public health research and to conduct surveys and studies in the area of public health.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* provide the authority for the Minister of Health to establish and administer a plan of medical care insurance for residents. *The Regional Health Services Act* provides the authority to establish 12 regional health authorities, replacing the former 32 district health boards.

Sections 3 and 9 of *The Cancer Agency Act* provide for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Department of Health, regional health authorities and the Saskatchewan Cancer Agency for 2006–07 are outlined in *The Department of Health Act, The Regional Health Services Act* and *The Cancer Agency Act*.

1.2 Reporting Relationship

The Department of Health is directly accountable, and regularly reports, to the Minister of Health on the funding and administering the funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report concerning the medical care insurance plan to the Legislative Assembly.

The Regional Health Services Act prescribes that a regional health authority shall submit to the Minister of Health:

- a report on the activities of the regional health authority; and
- a detailed, audited set of financial statements.

Section 54 of *The Regional Health Services Act* requires that regional health authorities and the Cancer Agency shall submit to the Minister any reports that the Minister may request from time to time. Regional health authorities and the Cancer Agency are required to submit a financial and health service plan to Saskatchewan Health.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to regional health authorities, the Saskatchewan Cancer Agency and to physicians and dental surgeons for insured physician and surgical-dental services.

Section 57 of *The Regional Health Services Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by a regional health authority and the Cancer Agency, shall audit the accounts of a regional health authority or the Cancer Agency at least once in every fiscal year. Each regional health authority and the Cancer Agency must annually submit to the Minister of Health a detailed, audited set of financial statements.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated representative.

The most recent audits were for the year ended March 31, 2007.

The audits of the Government of Saskatchewan, regional health authorities and Saskatchewan Cancer Agency are tabled in the Saskatchewan Legislature each year. The reports are available to the public directly from each entity or are available on their websites.

The Provincial Auditor's Office of Saskatchewan also prepares reports to the Legislative Assembly of Saskatchewan. These reports are designed to assist Government in managing public resources and to improve the information provided to the Legislative Assembly. They are available on the Provincial Auditor's website: http://www.auditor.sk.ca.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Regional Health Services Act was proclaimed on August 1, 2002, to replace *The Health Districts Act* as the authority to amalgamate the existing 32 health districts into 12 regional health authorities. Section 8 of *The Regional Health Services Act* (the Act) gives the Minister the authority to provide funding to a regional health authority or a health care organization for the purpose of the Act.

Section 10 of *The Regional Health Services Act* permits the Minister to designate facilities including hospitals, special-care homes and health centres. Section 11 allows the Minister to prescribe standards for delivering services in those facilities by regional health authorities and health care organizations that have entered into service agreements with a regional health authority.

The Act sets out the accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual operational and financial and health service plans for Ministerial approval (sections 50–51); establishing community advisory networks (section 28); and reporting critical incidents (section 58). The Minister also has the authority to establish a provincial surgi-cal registry to help manage surgical wait times (section 12). The Minister retains authority to inquire into matters (section 59); appoint a public administrator if necessary (section 60); and approve general and staff practitioner by-laws (sections 42–44).

Funding for hospitals is included in the funding provided to regional health authorities.

As of March 31, 2007, the following facilities were providing insured hospital services to both in- and out-patients:

- 66 acute care hospitals provided in- and out-patient services; and
- one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

A comprehensive range of insured services is provided by hospitals. These may include: public ward accommodation; necessary nursing services; the use of operating room and case room facilities; required medical and surgical materials and appliances; x-ray, laboratory, radiological and other diagnostic procedures; radiotherapy facilities; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all drugs, biological and related preparations required for hospitalized patients; and services rendered by individuals who receive remuneration from the hospital.

The Action Plan for Saskatchewan Health Care established new hospital categories and outlined a standard array of services that should be available in each hospital. Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals.

One of the elements of the Action Plan is to provide reliable, predictable hospital services, so people know what they can expect 24 hours a day, 365 days a year. While not all hospitals will offer the same kinds of services, reliability and predictability means:

- it is widely understood which services each hospital offers; and
- these services will be provided on a continuous basis, subject to the availability of appropriate health providers.

This service delivery framework will ensure quality, predictable hospital services and help guide decisions about where to invest new funds.

Regional health authorities have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available health professional funding resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, which takes into account such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. A regional health authority initiates the process and, depending on the specific service request, it could include consultations involving several branches within Saskatchewan Health as well as external stakeholder groups such as health regions, service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. All fee items for physicians can be found in the Physician's Newsletter:

www.health.gov.sk.ca/physician-information

The Saskatchewan Health Medical Services Branch 2006–2007 Annual Statistical Report is available on the website:

www.health.gov.sk.ca/msb-annual-reports.html

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra-billing for insured services.

As of March 31, 2007, there were 1,753 physicians licensed to practice in the province and eligible to participate in the medical care insurance plan.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The opted-out physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2007, there were no opted-out physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations (1994) of *The Saskatchewan Medical Care Insurance Act.*

There were approximately 3,300 different insured physician services as of March 31, 2007.

A process of formal discussion between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services (modernization) with significant monetary impact. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service or significant revisions occur to the Physician Payment Schedule, a regulatory amendment is made to the Physician Payment Schedule.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan. As of March 31, 2007, 74 dental specialists were providing such services.

Dentists may opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

There were no opted-out dentists in Saskatchewan as of March 31, 2007.

Insured surgical-dental services are limited to: services in connection with maxillo-facial surgery required as a result of trauma; treatment services for the orthodontic care of cleft palate; extraction of teeth when medically required for the provision of heart surgery, services for chronic renal disease and services for total joint replacement by prosthesis when a proper referral has been made and prior approval obtained from Medical Services Branch; and certain services in connection with abnormalities of the mouth and surrounding structures.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service.

Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include: in-patient and out-patient hospital services provided for reasons other than medical necessity; the extra cost of private and semi-private hospital accommodation not ordered by a physician; physiotherapy and occupational therapy services not provided by or under contract with a regional health authority; services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health; non-emergency cataract surgery, MRIs and bone densitometry provided outside Saskatchewan without prior written approval; non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval; non-medically required elective physician services; surgical-dental services that are not medically necessary; and services received under other public problems including *The Workers' Compensation Act*, the federal Department of Veteran Affairs and *The Mental Health Act*.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with regional health authorities, physicians and dentists. There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with regional health authorities, physicians and dentists.

Insured hospital services could be de-insured by the government if they were determined to be no longer medically necessary. The process is based on discussions among regional health authorities, practitioners and officials from the Department of Health.

Insured surgical-dental services could be de-insured if they were determined not to be medically necessary. The process is based on discussion and consultation with the dental surgeons of the province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if they were determined not to be medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2006–07.

3.0 Universality

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and The Medical Care Insurance Beneficiary and Administration Regulations define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage. The penalty provisions in section 11 of the Act (Duty to Register) provide for a fine of up to $50,000 for giving false information or withholding information necessary for registering an individual.

Eligibility is limited to residents. A "resident" means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor-in-Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following the establishing of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police (RCMP), federal inmates and refugee claimants; visitors to the province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the RCMP, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

3.2 Registration Requirements

The following process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident, other than a dependent child under 18 years, is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire in December 2008.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 and over living in the parental home or on their own must self-register.

The number of persons registered for health services in Saskatchewan on June 30, 2006 was 1,003,231.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, student permit or Minister's permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with an employment/student permit, Minister's permit or permanent resident, that is, landed immigrant, record.

On June 30, 2006, there were 5,642 such temporary residents registered with Saskatchewan Health.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada. There were no changes to the in-Canada temporary absence provisions in 2006–07.

Continued coverage during a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- employment of up to 12 months (no documentation required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority for paying in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of The Saskatchewan Medical Care Insurance Payment Regulations (1994) provides payment for physician services to Saskatchewan beneficiaries temporarily residing out-side the province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates. The reciprocal arrangement for physician services applies to every province except Quebec.

Payments/reimbursement to Quebec physicians, for services to Saskatchewan residents, are made at Saskatchewan rates (Saskatchewan Physician Payment Schedule). However, the physician fees may be paid at Quebec rates with prior approval. In recent years, the out-of-province reciprocal hospital per diem billing rates have increased significantly.

In 2006–07, expenditures for insured physician services in other provinces were $24.24 million. Insured hospital services in other provinces were $48.40 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations describe the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on the expiration of the approved period as follows:

- education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- contract employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations provides open-ended temporary absence coverage for persons whose principal place of residence is in Saskatchewan, but who are not able to satisfy the annual six months physical presence requirement because the nature of their employment requires travel from place to place outside Canada (e.g., cruise line workers).

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

In 2006–07, $2.47 million was paid for in-patient hospital services and $1.02 million was spent on out-patient hospital services outside Canada. In 2006–07, expenditures for insured physician services outside Canada were $692,600.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical out-of-province care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health and problem gambling services; and
- cataract surgery services, bone densitometry and non-urgent MRI.

Prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of Saskatchewan Health. The Saskatchewan Cancer Agency is consulted for out-of-country cancer treatment requests. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services are not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in providing public services, which include insured health services on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2007, Saskatchewan had 3,092 staffed hospital beds in 66 acute care hospitals, including 2,497 acute care beds, 213 psychiatric beds and 382 other beds. The Wascana Rehabilitation Centre had 48 rehabilitation beds and 204 extended care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

Saskatchewan's Health Workforce Action Plan

Working Together: Saskatchewan's Health Workforce Action Plan was released in December 2005. Extensive consultations took place with stakeholders in developing the plan. The Plan contains 5 goals, including:

- The health care system has a sufficient number and effective mix of health care professionals who are used fully to provide safe, high-quality care.
- The health system has safe, supportive, and quality workplaces that help to retain and recruit health care professionals.
- Aboriginal people fully participate in the health sector in all health occupations.
- The education and training supply of Saskatchewan health care professionals is aligned with projected workforce requirements and health service needs.
- The health workforce is innovative, flexible and responsive to changes in the health system.

A copy of Working Together: Saskatchewan's Health Workforce Action Plan can be found at: www.health.gov.sk.ca. In the last year, significant recruitment, retention and training initiatives were undertaken:

- A $25 million recruitment and retention fund was announced in the fall of 2006. $15 million dollars was targeted at nursing recruitment and retention programs, while $10 million was earmarked for recruitment and retention programs focused on allied health professionals.
- Two committees were also established to provide direction and advice related to this funding and to the actions outlined in the Workforce Action Plan. These two committees, the Provincial Health Workforce Steering Committee and the Provincial Nursing Committee, bring together the health partners that helped develop the Workforce Action Plan.
- The establishment of HealthCareersInSask, a provincial recruitment agency supporting the regional health authorities and the Saskatchewan Cancer Agency in filling health professional vacancies.
- The establishment of a $6 million Relocation and Northern/Rural/Hard to Recruit Grant Program.
- The development and implementation of a $6 million Health Workforce Retention Program.
- An increase in the number of training seats available in Saskatchewan for physicians and nurses (registered nurses and licensed practical nurses).

Supply of Health Providers

In looking at the trend of selected health professionals, the majority of Saskatchewan's health professionals have increased between 1995 and 2005 (Table 1).

Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services, Saskatchewan Health notes the following:

- MRI machines are located in Saskatoon (2) and Regina (2).
- CT scanners are available in Saskatoon (4), Regina (3), Prince Albert (1), Swift Current (1), Moose Jaw (1), Yorkton (1), North Battleford (1) and Lloydminster (1).
- Renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton, Swift Current, North Battleford, and Moose Jaw.
- Cancer treatment services are provided by the Saskatchewan Cancer Agency's two cancer clinics, the Saskatoon Cancer Centre and the Allan Blair Cancer Centre in Regina. In calendar year 2006, approximately 5,000 new patients began treatment for cancer. Both centres provided approximately 39,000 radiation therapy treatments and 18,000 chemotherapy treatments to cancer patients in Saskatoon and Regina.
- Sixteen (16) sites are involved in the Community Oncology Program of Saskatchewan (COPS) that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon. In 2006, over 1,000 patients made approximately 6,200 visits to COPS centres for treatment.

Table 1: Selected Health Professionals, Saskatchewan and Canada*

Occupations	Saskatchewan							Canada
	1997	2000	2001	2002	2003	2004	2005	2005
Chiropractors	14	16	16	18	18	18	19	22
Dental Hygienists	27	27	30	30	34	34	35	57
Dentists	34	34	35	35	38	38	37	58
Dietitians	n/a	n/a	22	23	24	25	25	25
Licensed Practical Nurses	214	151	n/a	199	207	214	221	200
Occupational Therapists	n/a	n/a	n/a	20	21	22	22	35
Optometrists	11	11	11	11	11	11	12	12
Pharmacists	105	109	111	107	115	118	119	91
Physiotherapists	48	52	52	51	53	53	54	49
Psychologists	7	7	n/a	n/a	n/a	41	42	45
Registered Nurses	823~	838	808	818	855	854	863	776

* Rates per 100,000 population.

n/a Data not available.

~ Datum was for 1998.

Source: Health Care Indicators, Canadian Institute for Health Information (CIHI): 2000 to 2007.

Note: Comparing the number of professionals per 100,000 population may not provide a good comparison, as it does not recognize the different ways health services are delivered.

- Approximately 73 percent of surgery services are provided in Saskatoon and Regina, where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 22 percent is provided in six mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster, with the remaining surgery performed in smaller hospitals across the province.
- Telehealth Saskatchewan links continue to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2006–07 to improve access to insured hospital services:

- Access and use of specialized medical imaging services, including MRI, CT and bone mineral density testing, has grown steadily in Saskatchewan. In 2006–07, approximately 14,425 patients received MRI services and approximately 69,240 patients received CT services
- Telehealth Saskatchewan has proven to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health continues to support the network. There are a total of 26 Telehealth Saskatchewan sites in the Province.
- The Chronic Renal Insufficiency (CRI) Clinics that were established in the Regina Qu'Appelle and Saskatoon regions in summer 2001 continue to grow. The goals of these clinics are to delay the need for dialysis and to better prepare patients in making their treatment choices: haemodialysis, peritoneal or home dialysis or transplant. The number of patients served by these clinics significantly surpasses the number of patients on dialysis. As of March 31, 2005, 817 patients were being supported through CRI clinics. By March 31, 2007 this had increased to 1,140.
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven sites around the province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program provides mammograms to between 34,000 and 37,000 women annually.
- The Prevention Program for Cervical Cancer is a Cancer Agency program that has the goal of increasing participation in regular pap testing and tracking follow-up of unsatisfactory and abnormal test results. In 2006 the program sent out 112,500 result notices and 260,000 notification/information letters.
- The Provincial Malignant Hematology/Stem Cell Transplant Program continues to provide transplants to Saskatchewan residents. In 2006–07, 33 patients with aggressive or advanced blood or other system cancers received stem cell or bone marrow transplants. The program also provides teaching as a formal part of the hematology clinic rotation for residents of Internal Medicine at the University of Saskatchewan.

Capital equipment purchases by regional health authorities are consistent with the criteria established under the February 2003 Health Accord. Regional health authority acquisitions are reviewed to ensure consistency with provincial health strategies and priorities and Health Accord principles. Capital equipment acquisitions in 2006–07 supported enhanced access to diagnostic imaging and surgical services.

Saskatchewan Health continues to place priority on promoting surgical access and improving the province's surgical system. Saskatchewan Health, with advice from the Saskatchewan Surgical Care Network (SSCN), is leading the country in implementing key surgical care system initiatives.

Saskatchewan has already developed and implemented a Patient Assessment Process, a Surgical Patient Registry and Target Time Frames for Surgery as part of Saskatchewan Health's Action Plan.

- The Patient Assessment Process increases consistency and fairness by standardizing the factors physicians use to assess their patients' level of need for surgery. This will help to ensure those with the greatest need for surgery will receive it first.
- The Surgical Patient Registry tracks patients needing surgery in the province. Information from this comprehensive database supports the surgical care system in improving the management of surgical access, determining system capacity and resource requirements, and reducing wait times for patients.
- Target Time Frames for Surgery support the health regions to better monitor and track patients and to help ensure they receive care according to their level of need. In March 2004, Target Time Frames for Surgery were announced as performance goals for the surgical care system. On the recommendation of the Saskatchewan Surgical Care Network (SSCN), the number of Priority Levels for surgery was reduced from the initial six levels to four levels (plus emergency surgery which is to be recorded and reported separately) as of April 2006, to give surgeons and regions more flexibility in managing wait lists to shorten maximum wait times.

In January 2003, the Saskatchewan surgical website was launched. Located at [www.sasksurgery.ca] this surgical access website provides a range of surgical care system information and wait list information, including wait time and wait list data, and physician location and specialty. The website also provides information on surgeries performed, patients waiting and waiting times, as well as how the system works and how to access surgical services in the province.

Saskatchewan Health is currently working closely with members of the health regions, physicians and other health partners to maximize access to diagnostic imaging services in Saskatchewan. The focus is on improving access to specialized diagnostic services (MRI, CT), while at the same time providing a basis for improved, sustainable health delivery in the future.

On January 31, 2005, the Minister of Health announced the establishment of a Diagnostic Imaging Network. This Network is a partnership among clinicians, service providers, regional health authorities, regulatory agencies, health training institutions, community and government representatives, that works toward the goal of ensuring equitable access to quality diagnostic imaging services in Saskatchewan. Through collaboration with participating partners, the Network acts as a provincial advisory body to assist in province-wide strategic planning and coordination of the diagnostic imaging system.

The Network is currently overseeing the following initiatives:

- Implementation of a Radiology Information and Picture Archiving and Communication System (RIS/PACS) in the Province. The RIS is a system for tracking patients and diagnostic imaging procedures that are provided to them. The PACS is a system that allows for the viewing, storage and retrieval of a digital diagnostic image.
- Development of a multi-year Capital Equipment Replacement Plan: Saskatchewan Health and Regional Health Authorities have created an inventory of the Province's diagnostic imaging equipment and developed a plan for the acquisition and deployment of future diagnostic imaging equipment purchases.
- Development and implementation of a Provincial Waiting Time Definition, Urgency Classifications, and Waiting Time Benchmarks for MRI and CT: These guidelines standardize diagnostic imaging procedure waiting times for MRI and CT, and establish waiting time performance goals.

- A Provincial Decision Support Tool pilot project: A decision support tool for diagnostic imaging will assist the referring physician in ordering the right test the first time by incorporating evidence-based guidelines for radiology into a quick, user friendly electronic order entry tool.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2007, there were 1,753 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 1,003 (57.2 percent) were family practitioners and 750 (42.8 percent) were specialists.

As of March 31, 2007, there were approximately 380 practising dentists and dental surgeons located in all major centres in Saskatchewan. Seventy-four provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2005–2006 to recruit and retain physicians thereby enhancing access to insured physician services and reducing waiting times.

Specialist Programs:

- A Specialist Physician Enhancement Training Program provides grants of up to $80,000 per year to allow practicing specialists the opportunity to obtain additional training and requires a return service commitment.
- A Specialist Emergency Coverage Program compensates specialist physicians who make themselves available to provide emergency coverage to acute care facilities.
- The Specialist Resident Bursary Program offers up to 15 bursary spots per year to residents for a maximum of three years funding with a return-of-service commitment.

Rural and Regional Programs:

- The Regional Practice Establishment Program provides grants of $10,000 to eligible family physicians who establish a practice in a regional centre for a minimum of 18 months.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program, which compensates physicians providing emergency room coverage in rural areas and helps those communities with fewer than three physicians gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Programs make grants of $18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Family Medicine Resident Bursary Program provides bursaries of $25,000 to family medicine residents to help them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $15,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training Program provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- The Rural Emergency Care Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program.

- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to help stabilize the supply of physicians in northern Saskatchewan.
- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

Other Programs:

- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services Program.
- A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.
- The Parental Leave Program was developed in 2004 to provide benefits for self-employed physicians who take a maternity, paternity or adoption child care leave from clinical practice.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by section 48 of *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the government providing notice to begin discussing a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn select a third member; and
- the Board has the authority to make a decision binding on the parties.

The latest three-year agreement with the Saskatchewan Medical Association, which expires March 31, 2009, provided increases in the Physician Payment Schedule of 2.8 percent in each year of the agreement. Similar increases were applied to non-fee-for-service physicians. Additional improvements included a total of $11.8 million to support a number of innovative incentive programs focussing on recruitment, retention and improved patient care. These include:

- increases to existing on-call programs;
- $42 million to improve patient access to specialists;
- $42 million to introduce on-call payment for some urban family physicians and to support improve compensation to family physicians who provide assistance during surgery;
- $4 million to enhance management of chronic diseases; and
- $3.8 million to improve ongoing retention programs.

Section 6 of The Saskatchewan Medical Care Insurance Payment Regulations, 1994, outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services. Total expenditures for in-province physician services and programs in 2006–07 amounted to $586.6 million: $369.3 million for fee-for-service billings; $20.8 million for Emergency Coverage Programs; $164.2 million in non-fee-for-service expenditures; and $32.4 million for Saskatchewan Medical Association programs as outlined in the agreement.

5.5 Payments to Hospitals

In 2006–07, funding to regional health authorities was based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. Each regional health authority is given a global budget and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes.

Regional health authorities may receive additional funds for providing specialized hospital programs (e.g., renal dialysis, specialized medical imaging services, specialized respiratory services and surgical services) or for providing services to residents from other health regions.

Payments to regional health authorities for delivering services are made pursuant to section 8 of *The Regional Health Services Act*. The legislation provides the authority for the Minister of Health to make grants to regional health authorities and health care organizations for the purposes of the Act and to arrange for providing services in any area of Saskatchewan if it is in the public interest to do so.

Regional health authorities provide an annual report on the aggregate financial results of their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in the Department of Health 2006–07 Annual Report, the Government of Saskatchewan 2006–07 Annual Budget and related budget documents, its 2006–07 Public Accounts, and the Quarterly and Mid-Year Financial Reports. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents.

Federal contributions have also been acknowledged on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums.

7.0 Extended Health Care Services

As of March 31, 2006, the range of extended health care services provided by the provincial government included long-term residential care services for Saskatchewan residents, certain community-based health services such as home care, as well as a wide range of other health, social support, mental health, addiction treatment and drug benefit programs.

Nursing Home Intermediate Care Services

Special-care homes provide institutional long-term care services to meet the needs of individuals, primarily with heavy care needs. Services offered include care and accommodation, respite care, day programs, night care, palliative care and, in some instances, convalescent care. These facilities are publicly funded by Saskatchewan Health through regional health authorities and are governed by *The Housing and Special-care Homes Act* and regulations.

Public Health Services of regional health authorities provide immunization for residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services. This applies to influenza and pneumococcal vaccines.

Home Care Services

The Home Care Program provides an option for people with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals with palliative, acute and supportive care needs. Services include assessment and care coordination, nursing, personal care, respite care, homemaking, meals, home maintenance, therapy and volunteer services. Individualized funding is an option of the Home Care Program. It provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is funded by Saskatchewan Health, delivered by the Regional Health Authorities, and governed by *The Regional Health Services Act.*

Ambulatory Health Care Services

Saskatchewan regional health authorities provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act.*

Regional health authorities offer podiatry services. Services include assessment, consultation and treatment. The Chiropody Services Regulation of *The Department of Health Act* provides chiropodists and podiatrists with the ability to self-regulate their profession.

Regina Qu'Appelle and Saskatoon regional health authorities provide a Hearing Aid Program. Services include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Hearing Aid Act* and regulations and *The Regional Health Services Act* govern these programs.

Rehabilitation therapies, including occupational and physical therapies and speech and language pathology, are offered by the regional health authorities to help individuals of all ages improve their functional independence. Services are provided in hospitals, rehabilitation centres, long-term care facilities, community health centres, schools and private homes and include assessment, consultation and treatment. *The Regional Health Services Act* and The Community Therapy Regulations, which are under the authority of *The Department of Health Act*, govern these programs.

Adult Residential Care Services — Mental Health Services:

Apartment Living Programs and Group Homes provide a continuum of support and living assistance to individuals with long-term mental illnesses. These programs are governed by *The Residential Services Act.*

Saskatchewan Health, in partnership with the Heartland Regional Health Authority, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and abides by the *Registered Charities* and *The Income Tax Act*, and *The Regional Health Services Act.*

Alcohol and Drug Services:

The provision of Alcohol and Drug services generally falls under *The Regional Health Services Act.* Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the regional health authorities contract with community-based and non-profit organizations governed by *The Non-profit Corporations Act* to provide services.

Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and/or other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days.

In-patient services are provided to individuals requiring intensive rehabilitative programming for their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs.

Long-term residential services provide maintenance and transition programs for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse-prevention in a safe and supportive environment.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).[1]	1,024,827	1,007,753	1,018,057	1,021,080	1,003,231

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	65	6	65	66	66
b. chronic care	0	0	0		
c. rehabilitative care	1	1	1	1	1
d. other	0	0			
e. total	66	67	66	67	67
3. Payments for insured health services ($):					
a. acute care	not available	811,561,671 [2]	867,261,000 [2]	922,675,000 [2]	1,173,115,000 [3]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not available	not available [4]	not available [4]	not available [4]	not applicable [4]
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	not available	811,561,671	867,261,000	922,675,000 [2]	1,173,115,000 [3]
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

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[1] Saskatchewan's numbers are for June 30.

[2] This number includes estimated government funding to Regional Health Authorities (RHAs) based on total projected expenditures less non-government revenue, as provided to Saskatchewan Health through the RHA annual operational plans.
- Acute care funding includes: acute care services, specialized hospital services, and in-hospital specialist services.
- Does not include inpatient rehabilitative care, inpatient mental health, or addiction treatment services.
- Does not include payments to Saskatchewan Cancer Agency for outpatient chemotherapy and radiation.

[3] Comparable annual information is not available at this time.

[4] This number is based on audited operating expenditures of Regional Health Authorities (RHAs), as published in Saskatchewan Health's annual report. As the majority of funding for actue care is provided by the Ministry, the use of actual expenditures rather than budget (RHA operational plans) reflects more accurately the funding provided by the Province.
- Acute care funding includes: acute care services, specialized hospital services, and in-hospital specialist services.
- Does not include inpatient rehabilitative care, inpatient mental health, or addiction treatment services.
- Does not include payments to Saskatchewan Cancer Agency for outpatient chemotherapy and radiation.

Insured Hospital Services Provided to Residents in Another Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	4,422	4,561	4,307	4,566	4,627
7. Total payments, in-patient ($).	23,447,100	30,528,100	30,461,943	33,671,100	36,828,100
8. Total number of claims, out-patient (#).	50,401	45,510	51,678	55,067	52,591
9. Total payments, out-patient ($).	7,144,800	6,405,900	9,345,190	11,044,200	11,573,400
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	287	231	254	248	242
11. Total payments, in-patient ($).	1,891,800	728,400	730,849	2,033,300	2,473,400
12. Total number of claims, out-patient (#).	1,049	875	1,002	1,194	1,454
13. Total payments, out-patient ($).	359,400	373,300	251,957	1,486,500	1,019,500

Insured Physician Services Within Own Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	936	946	967	990	1,003
b. specialists	700	716	718	729	750
c. other	0	0	0	0	0
d. total	1,636	1,662	1,685	1,719	1,753
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	421,709,330	449,108,573	491,805,817	528,759,380	554,193,389
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	10,269,461	9,933,689	9,970,606	10,033,881	9,944,187
b. total payments ($)	290,471,821	304,538,785	337,816,629	362,884,810	369,664,529

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
19. Number of services (#).	458,100	509,784	513,694	542,651	603,687
20. Total payments ($).	16,948,900	19,477,300	20,379,200	20,541,894	24,239,622
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	not available	not available	not available	not available	not available
22. Total payments ($).	1,129,300	583,200	510,600	695,900	692,600

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
23. Number of participating dentists (#).	94	94	84	78	74
24. Number of services provided (#).	18,500	18,300	19,400	18,511	18,203
25. Total payments ($).	1,264,200	1,345,900	1,442,800	1,539,420	1,511,882

Alberta

Introduction: Alberta's Health Care System

Alberta provides medically necessary, insured services in a public system that follows the principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility. Medically necessary services include hospital and physician services and specific kinds of services provided by oral surgeons and other dental professionals.

Health System Governance

Alberta's health care system is defined in legislation and is governed by the Minister of Health and Wellness. The Alberta Ministry of Health and Wellness provides strategic direction and leadership to the provincial health system. This role includes developing the overall vision for the health system, defining provincial goals, objectives, standards and policies, encouraging innovation, setting priorities and allocating resources. The Ministry's role is to assure accountability and balance health service needs with fiscal responsibility. The Ministry of Health and Wellness also has a major role in protecting and promoting public health. This role includes: (1) monitoring the health status of the population, (2) identifying and working toward reducing or eliminating risks posed by communicable diseases and food-borne, drug and environmental hazards, (3) providing appropriate information to prevent the onset of disease and injury and (4) promoting healthy choices.

The *Regional Health Authorities Act* makes regional health authorities responsible to the Minister of Health and Wellness for ensuring the provision of health services that are responsive to the needs of individuals and communities. Regional health authorities ensure the provision of acute care hospital services, community and long-term care services, mental health services, public health protection and promotion services, and other related services. The *Cancer Programs Act* makes the Alberta Cancer Board responsible to the Minister for providing cancer prevention and treatment services, education and research. The *Alcohol and Drug Abuse Act* makes the Alberta Alcohol and Drug Abuse Commission responsible to the Minister for providing services to address alcohol, other drug and gambling problems, and to conduct related research. The Alberta Mental Health Board advises the Minister on strategic and policy matters related to mental health programs and services. The Health Quality Council of Alberta promotes patient safety and health service quality on a province-wide basis. The Council assists in the implementation and evaluation of strategies designed to improve patient safety and health service quality, and surveys Albertans on their experience and satisfaction with health services. Regional health authorities, provincial health boards and agencies are also responsible for assessing needs, setting priorities, allocating resources and monitoring performance for the continuous improvement of health service quality, effectiveness and accessibility. Alberta's health legislation can be accessed at:

http://www.health.alberta.ca/about/Minister_legislation.html

Significant Events in 2006/2007

In 2006/2007, the Alberta Ministry of Health and Wellness continued to pursue its goal of improving the performance and accessibility of the health system in meeting the needs of Albertans. Some key achievements include:

- The new overarching mental health framework, entitled *Positive Futures — Optimizing Mental Health for Alberta's Children and Youth: A Framework for Action (2006–2016)*, was released.
- The Newborn Metabolic Screening Program was expanded to include screening for 17 additional disorders such as cystic fibrosis.
- The Alberta Provincial Stroke Strategy was launched. The strategy is a partnership between the provincial government, regional health authorities and the Alberta Heart and Stroke Foundation and gives Albertans enhanced access to appropriate stroke treatment and care. The aim of the strategy is to reduce the rate of strokes and improve treatment and rehabilitation outcomes.
- The *Cancer Prevention Legacy Act* was proclaimed in May 2006. The Act helps in building a cancer-free future for Albertans, and demonstrates Alberta's commitment to becoming a leader in the fight against cancer. The Act established a $500 million Alberta Cancer Prevention Legacy Fund to support initiatives in cancer prevention, screening, and education.
- Five new Primary Care Networks were established, bringing the total across Alberta to 19. These networks involve over 900 physicians and provide services to more than one million Albertans.
- The Health Quality Council of Alberta was granted status as a provincial health board under the *Regional Health Authorities Act* on July 1, 2006. The council is a catalyst for change in the health system, and serves as an independent body to measure, monitor and assess patient safety and health service quality throughout the province.
- The draft Health Policy Framework was released on February 28, 2006. It outlined Alberta's policy directions for reforming the health system to enhance sustainability, flexibility and accessibility. The Minister held extensive public consultations during March 2006, following which a report entitled *What We Heard* was made public. Albertans indicated their support for health system renewal, but did not agree with allowing physicians to work in both the public and private systems, and did not agree with allowing individuals to pay privately for quicker access to services. Based on this, the Health Policy Framework was revised and published in August 2006.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Government Organization Act* describes the departments of government that are to be administered by Ministers in Alberta. Schedule 7 to this Act sets out the specific powers, duties and functions to be exercised or performed by the Minister of Health and Wellness. The Ministry of Health and Wellness administers the Alberta Health Care Insurance Plan on a non-profit basis and in accordance with the *Canada Health Act.* Since 1969, the *Alberta Health Care Insurance Act* has governed the operation of the Alberta Health Care Insurance Plan. The Minister determines which services are covered by the Alberta Health Care Insurance Plan. The Ministry reviews scientific literature, consults with expert advisors, assesses policy, and considers the funding and training that is required when deciding which medical products, services or devices will be covered under the Alberta Health Care Insurance Plan.

The Ministry of Health and Wellness registers eligible Alberta residents for coverage under the Plan and pays practitioners for insured services listed in the Schedule of Medical Benefits and the Schedule of Oral and Maxillofacial Surgery Benefits. The Ministry also provides funding to regional health authorities and provincial boards for the provision of insured hospital services.

1.2 Reporting Relationship

The Minister of Health and Wellness is fully accountable for the Alberta Health Care Insurance Plan, which is managed by the Minister's departmental staff. Under the *Government Accountability Act*, sections 13 and 14, the Minister must prepare a business plan and an annual report for each fiscal year. The *Alberta Ministry of Health and Wellness Three-Year Business Plan 2006 to 2009* was tabled in the Alberta Legislature on March 22, 2006. The Ministry's annual report documents the health care system's key activities including the Alberta Health Care Insurance Plan and provides consolidated financial statements for the previous fiscal year. It also provides information about key achievements and results in response to key performance measures and targets included in the previous year's business plan. The 2006/2007 Annual Report of the Alberta Ministry of Health and Wellness was publicly released September 27, 2007 and can be accessed at:

http://www.health.alberta.ca/resources/AR07.html

The Ministry also issues an annual statistical supplement on data related to the Alberta Health Care Insurance Plan. An announcement will be made when the 2006/2007 statistical supplement is available.

Under the *Government Accountability Act*, section 16, "accountable organizations" (regional health authorities and provincial health boards) must prepare and provide to the Minister a business plan and annual report for each fiscal year. In addition, under the *Regional Health Authorities Act*, section 9, regional health authorities and provincial health boards must provide to the Minister a health plan indicating how the authority will carry out its responsibilities under section 5 of the Act and how its performance will be measured. Health plans and business plans must be provided to the Minister by March 31 of each year. Health authority annual reports are due to the Minister by July 31 of each year, and are tabled in the Alberta Legislature within 15 days of the beginning of the next session.

1.3 Audit of Accounts

The Auditor General of Alberta is the auditor of all government ministries, departments, regulated funds, and provincial agencies and is responsible for assuring the public that the government's financial reporting is credible. The Auditor General reports on the adequacy of regulatory administration, management structures, accounting systems and management control systems, including those designed to ensure economy and efficiency. The Auditor General of Alberta audits the performance reporting, records and financial statements of the Ministry of Health and Wellness as well as regional health authorities and provincial health boards.

The Ministry was subjected to a complete Financial Statement audit by the Auditor General of Alberta. The statements of operations and cash flows as well as the statement of financial position were audited. The audit was conducted in accordance with Generally Accepted Auditing Standards and included examining evidence supporting the amounts and disclosures in the financial statements. The audit also included assessing the accounting principles used and significant estimates made by the Ministry of Health and Wellness and the overall financial statement presentation. The draft auditor's reports, dated June 11, 2007, indicated that the statements fairly present, in all material respects, the financial position and results of operations for the year ended March 31, 2007.

2.0 Comprehensiveness

2.1 Insured Hospital Services

In Alberta, regional health authorities are responsible to the Minister for ensuring the provision of insured hospital services with the exception of cancer hospitals, which are the responsibility of the Alberta Cancer Board. The *Hospitals Act*, the Hospitalization Benefits Regulation (AR 244/1990), the *Health Care Protection Act* and the Health Care Protection Regulation (AR 208/2000) define how insured services are provided by hospitals or designated surgical facilities. According to the legislation, the Minister must approve all hospitals and surgical facilities. A directory of approved hospitals in Alberta can be found at:

http://www.health.alberta.ca/regions/RHA_map.html

During 2006/2007, no amendments were made to the legislation regarding insured hospital services.

Alberta's *Health Care Protection Act* governs the provision of surgical services through non-hospital surgical facilities. Ministerial approval of a contract between the facility operator and a regional health authority is required to provide insured services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta are also required. According to the College, there are currently 60 non-hospital surgical facilities with accreditation status. Of these, 27 facilities have contracts with regional health authorities to provide insured services.

According to the *Health Care Protection Act*, Ministerial approval for a contractual agreement shall not be given unless:

- the insured surgical services are consistent with the principles of the *Canada Health Act*;
- there is a current and likely future need for the services in the geographical area;
- the proposed surgical services will not have a negative impact on the province's public health system;
- there will be an expected benefit to the public;
- the regional health authority has an acceptable business plan to pay for the services;
- the proposed agreement contains performance expectations and measures; and
- the physicians providing the services will comply with the conflict of interest and ethical requirements of the *Medical Profession Act* and bylaws.

The publicly funded services provided by approved hospitals in Alberta range from the most advanced levels of diagnostic and treatment services for in-patients and out-patients to the routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are established in the Hospitalization Benefits Regulation (AR244/1990). The Regulation is available at:

http://www.health.alberta.ca/about/Minister_legislation.html

2.2 Insured Physician Services

The *Alberta Health Care Insurance Act* governs the payment of physicians for insured physician services under the Alberta Health Care Insurance Plan (section 6). Only physicians who meet the requirements stated in the *Alberta Health Care Insurance Act* are allowed to provide insured services under the Alberta Health Care Insurance Plan. In addition to physician services, a number of other practitioner services are covered or partially covered under the Alberta Health Care Insurance Plan. They include services provided by chiropractors, denturists, dentists, opticians, optometrists and podiatrists.

As of March 31, 2007 there were 7,411 practitioners enrolled in the Alberta Health Care Insurance Plan. Before being registered with the Alberta Health Care Insurance Plan, a practitioner must complete the appropriate registration forms and include a copy of his or her license issued by the appropriate governing body or association, such as the College of Physicians and Surgeons of Alberta. Under section 8 of the *Alberta Health Care Insurance Act*, physicians may opt-out of the Alberta Health Care Insurance Plan. As of March 31, 2007 there were no opted-out physicians in the province.

The Alberta Health Care Insurance Regulation defines which services are not deemed to be either basic or extended health services. The Medical Benefits Regulation establishes the benefits payable for insured medical services provided to residents of Alberta. Descriptions of those services are set out in the Schedule of Medical Benefits, which can be accessed at:

http://www.health.alberta.ca/professionals/somb.html

The Schedule of Medical Benefits is continuously revised and updated. In 2006/2007, the Schedule was revised to include an assessment of an unrelated condition in association with a workers' compensation or third party payer; ocular ultrasonography for cataract surgery and diagnosis and measurement of intraocular lesions; and percutaneous closure for atrial septal defects. In addition, the schedule was extensively revised to reimburse physicians for the anesthetic portion of new podiatric surgery services.

Insured physician services and any changes to the Schedule of Medical Benefits are negotiated among the Alberta Ministry of Health and Wellness, the Alberta Medical Association (AMA) and the regional health authorities. All changes to the Schedule of Medical Benefits require ministerial approval.

2.3 Insured Surgical-Dental Services

In Alberta, a dentist may perform a small number of insured surgical-dental services, but the majority of procedures can be billed to the Alberta Health Care Insurance Plan only when performed by a dentist certified as an oral and maxillofacial surgeon who meets the requirements stated in the *Alberta Health Care Insurance Act*. Under section 7 of the *Alberta Health Care Insurance Act*, all dentists are deemed to have opted into the plan. A dentist may opt out of the plan by notifying the Minister in writing of the effective date of their opting out and ensuring that each patient is advised of their opted out status before any service is provided to the patient. As of March 31, 2007 there were no dentists opted out of the Plan in Alberta.

Alberta insures a number of medically necessary oral surgical and dental procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits available at:

http://www.health.alberta.ca/professionals/allied.html

In 2006/2007, there were 220 dentists/oral surgeons who provided insured services under the Alberta Health Care Insurance Plan. Although there is no formal agreement between dentists and the Alberta Ministry of Health and Wellness, the department meets with members of the Alberta Dental Association and College to discuss changes to the Schedule of Oral and Maxillofacial Surgery Benefits. All changes to the benefit schedule require ministerial approval.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 12 of the Alberta Health Care Insurance Regulation defines what services are not considered to be insured services. Section 4(2) of the Hospitalization Benefits Regulation provides a list of uninsured hospital services.

Alberta's Policy for Preferred Accommodation and Non-Standard Goods or Services is posted on the Ministry website at:

http://www.health.alberta.ca/regions/PrefAcc.pdf

The policy describes the province's expectations of regional health authorities and guides their decision-making with respect to provision of preferred accommodation and enhanced or non-standard goods and services. This policy framework requires regional health authorities to provide 30 days advance notice to other regional health authorities and the Minister's designate regarding the categories of preferred accommodation offered by the health region and the charges associated with each category. Regional health authorities are also required to provide 30 days advance notice to other regional health authorities and the Minister's designate regarding any goods or services that will be provided as non-standard goods or services. They are also required to provide information about the associated charges for these goods or services, and when applicable, the criteria or clinical indications that may qualify patients to receive them as a standard good or service. Finally, each regional health authority must publish and keep current a list of non-standard medical goods or services; these lists are periodically reviewed by the Ministry of Health and Wellness and the regional health authorities.

3.0 Universality

3.1 Eligibility

Under the terms of the *Alberta Health Care Insurance Act*, all Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes the province his or her home, and is ordinarily present in Alberta. The term "resident" does not include a tourist, transient or visitor to Alberta. Persons moving permanently to Alberta from outside Canada are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. Temporary residents may also be eligible for coverage, if they intend to remain in Alberta for 12 months and their Canada entry documents are in order.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan include:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank in it; and
- persons serving a term in a federal penitentiary.

During 2006/2007, no amendments were made to the legislation regarding eligibility.

3.2 Registration Requirements

All new Alberta residents are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan. Family members are registered on the same account for premium billing purposes. New residents in Alberta should apply for coverage within three months of arrival. For persons moving from outside Canada their registration is effective as of the day they become an Alberta resident. However they are not eligible for subsidized premiums for the first 12 months of residence in Alberta. The Alberta Health Care Insurance Plan processes for registering Albertans and issuing replacement health cards require registrants to provide documentation that proves their identity, legal entitlement to be in Canada and Alberta residency. [illegible]e requirements have improved security and confidentiality, while reducing the potential for fraud or abuse. As of March 31, 2007, there were 3,384,625 Alberta residents registered with the Alberta Health Care Insurance Plan. Under the *Health Insurance Premiums Act* a resident may opt out of the Alberta Health Care Insurance Plan by filing a declaration with the Minister. As of March 31, 2007 there were 255 Alberta residents opted out of the Plan.

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits. There were 29,477 people covered under these conditions as of March 31, 2007.

3.4 Premiums

The majority of Alberta residents are required to pay premiums. Exceptions include:

- dependants (residents, however, are required to pay premiums on behalf of their dependants);
- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank in it;
- persons serving a term in a federal penitentiary;
- seniors aged 65 and older, their spouses and dependants;
- individuals enrolled in special groups such as Alberta Widows' Pension or income support programs;
- anyone eligible for full premium assistance; and
- any resident who elects to opt-out of the plan.

Although Albertans are required to pay premiums, no resident is denied service due to an inability to pay. Two programs help lower-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program.

4.0 Portability

4.1 Minimum Waiting Period

Under the *Alberta Health Care Insurance Act*, persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

The Alberta Health Care Insurance Plan provides coverage for the first 12 months of absence to eligible Alberta residents who temporarily leave Alberta for other parts of Canada. Residents who wish to maintain coverage for a longer period may apply for the following extensions of coverage:

- four years (48 months) if the absence is due to work, business or missionary service;
- two years (24 months) if the absence is due to travel, personal visits or an educational leave (sabbatical); and
- duration of studies if absence is due to full-time attendance at an accredited educational institute.

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy the Ministry of Health and Wellness that Alberta is their permanent and principal place of residence.

Alberta participates in the inter-provincial hospital and medical reciprocal agreements. These agreements were established to minimize complex billing processes and help ensure timely payments to health practitioners and hospitals when they provide services to residents from other provinces/territories (Quebec does not participate in the medical reciprocal agreement). Under these agreements, Alberta pays for insured services Albertans receive in other parts of Canada at the host province or territorial rates. In 2006/2007, no amendments were made to the legislation regarding in-Canada portability. During 2006/2007, Alberta paid $53.7 million for emergency in-patient and out-patient hospital services provided to Alberta residents in other provinces. More information on coverage during temporary absences outside Alberta is available at:

http://www.health.alberta.ca/ahcip/ahcip_travel.html

4.3 Coverage During Temporary Absences Outside Canada

The Alberta Health Care Insurance Plan provides coverage for the first six consecutive months of temporary absence from Canada. Residents who wish to maintain coverage for a longer period may apply for the following extensions of coverage:

- four years (48 months) if the absence is due to work, business or missionary service;
- two years (24 months) if the absence is due to travel, personal visits or an educational leave (sabbatical); and
- duration of studies if absence is due to full-time attendance at an accredited educational institute.

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy the Ministry of Health and Wellness that Alberta is their permanent and principal place of residence.

The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day (not including day of discharge). The maximum hospital out-patient visit rate is $50 (Canadian), with a limit of one visit per day. The only exception is haemodialysis, which is paid at a maximum of $341 per visit, with a limit of one visit per day. Physician and allied health practitioner services are paid according to Alberta rates. More information on coverage during temporary absences outside Canada is accessible at:

http://www.health.alberta.ca/ahcip/ahcip_travel.html

In 2006/2007, no amendments were made to the legislation regarding the portability of health insurance. During 2006/2007, Alberta paid $1.6 million for insured in-patient and out-patient emergency services provided to Albertans in another country.

4.4 Prior Approval Requirement

Prior approval is not required for elective insured services received in another Canadian province/territory, except for high-cost items not included in reciprocal agreements such as gender reassignment surgery, and gamma knife surgery. Prior approval is required for elective services received out-of-country and will only be given for insured services that are medically required, are not experimental, and are not available in Alberta or elsewhere in Canada. Approval must be received before these services can be covered.

5.0 Accessibility

5.1 Access to Insured Health Services

All Alberta residents have access to provincially funded and insured health services regardless of where they live in the province. In the province, nine regional health authorities, the Alberta Cancer Board, the Alberta Mental Health Board and the Health Quality Council of Alberta cooperate with each other to ensure that all Albertans have access to needed health services. There are two major metropolitan regions, Calgary Health Region and Capital Health (Edmonton), which provide provincially funded, province-wide services to Alberta residents who need tertiary-level diagnostic and treatment services.

Alberta is committed to ensuring that Albertans have access to new health services and technologies, and that they are introduced based on clinical and economic evidence that respects benefits and costs. The Alberta Health Technologies Decision Process and the Alberta Advisory Committee on Health Technologies have been established to support coverage and funding decisions at the provincial level related to non-pharmaceutical services and technologies using an evidence-informed process.

5.2 Access to Insured Hospital Services

The Ministry of Health and Wellness, regional health authorities, the Alberta Cancer Board, and the Alberta Mental Health Board actively participate in a health workforce planning process to ensure an adequate supply of key personnel. The key professions utilized in providing insured hospital services include: physicians, nurses (RNs, LPNs, RPNs), pharmacists, rehabilitation therapists (OTs, PTs, RTs) and clinical support personnel. As of March 31, 2007 there were approximately 52,700 health workforce practitioners in Alberta. These professions combined comprise approximately half of the total workforce employed in the province.

Health authorities are required to develop capital equipment plans as part of their annual business plan submissions to the Minister of Health and Wellness. Funding for regional health authorities and provincial boards in 2006/2007 (which includes health services, hospitals, medical equipment and province-wide services) was $6.1 billion.

The Ministry's 2006–2009 capital plan provided funding to renovate and expand existing health care facilities and to construct new facilities. Major expansions of existing hospitals are occurring in Calgary, Edmonton, Lethbridge, Rimbey, Edson, Barrhead and Viking. New hospitals are being constructed in Calgary, Sherwood Park, Fort Saskatchewan and High Prairie. As well, older long-term care facilities are being replaced in Red Deer, High Prairie, Vermilion and Vegreville. Work continues on the construction of the new Mazankowski Alberta Heart Institute in Edmonton. The new facility, which is nearing completion, will enhance cardiac treatment options available to Albertans and advance priority research and innovation initiatives for both Capital Health and the University of Alberta. Due to rapidly escalating construction costs, the budgets for many capital projects over the past year have increased beyond what was originally established. To help off-set these additional costs, the government allocated an additional $221 million to address cost escalation pressures on health projects for 2007–2010.

Province-wide services funding was provided toallow for expanded coverage of ocular photodynamic therapy. This expanded coverage is helping to prevent blindness in older Albertans. Access to mental health services for children was established as a top priority for the Ministry. Wait time goals for children's mental health services were developed and distributed to all the health regions in October 2006. The Alberta Mental Health Board and the regional health authorities have begun planning towards the achievement of these wait time goals.

5.3 Access to Insured Physician and Dental-Surgical Services

A draft Health Workforce Action Plan was developed to address critical labour shortfalls in the health system and has been submitted to government for final approval. This plan has two parts. The first is about changing the workforce to support changes in service delivery, while the second is about expanding the capacity of the workforce to ensure a future supply of health workers. As part of the overall Health Workforce Action Plan, a Rural Workforce Action Plan was developed to address current and future rural health workforce shortages through a variety of province-wide recruitment and retention strategies.

Some of the actions taken to improve access to physician and dental services include:

- Five new Primary Care Networks were added bringing the total across Alberta to 19. These networks involve over 900 physicians and provide services to more than one million Albertans. Primary Care Networks use a team approach to coordinate care for their patients. Family physicians working in these networks are better able to integrate and link their service with such regional services as home care. In so doing, family physicians work closely with other health providers such as nurses, dieticians, pharmacists, physiotherapists and mental health workers.

- The Aboriginal Health Careers Bursary program provided assistance to 62 Aboriginal student recipients. These bursaries are helping Aboriginal students to continue pursuing careers in health-related occupations.
- The Ministry allocated $8 million in March 2007 to help support physicians who are teaching medical residents. This additional funding has allowed for more medical residents to receive the training they need to meet clinical practicum and educational requirements.
- The Ministry worked in collaboration with Alberta Advanced Education and Technology to help meet future health workforce needs in Alberta. The government committed funding to create 467 new spaces for nursing students, starting September of 2007, to fill a growing demand for nurses in the province. In Edmonton, 207 nursing spaces will be added at Grant MacEwan College. In Calgary, a new four-year nursing degree program at Mount Royal College will have room for 260 students. The new spaces mean there could be 3,200 students enrolled in nursing degree programs across Alberta by the fall of 2007.
- The Provincial Nominee Program filled 37 allocations in 2006/2007. The program grants international medical graduates permanent citizenship status enabling them to stay in the country and continue to provide health services. Since the Provincial Nominee Program allows for fast-tracking of citizenship, it has been effective in attracting health care workers to Alberta.
- The Minisry provided a grant to the University of Alberta,Department of Dentistry to support the DentalOutreach Program. This program allowed dental students to refine their skills while providing greatly needed dental services to under-served and remote communities throughout Alberta.

5.4 Physician Compensation

The *Alberta Health Care Insurance Act* governs the payment of physicians. Most physicians are compensated through the Alberta Health Care Insurance Plan on a traditional, volume-driven, fee-for-service basis. Alternate Relationship Plans (ARPs) and Primary Care Networks for specialists and family physicians offer alternative compensation models to the fee-for-service payment system and contribute to better health outcomes by supporting innovative health care delivery.

Physician compensation is negotiated as part of a tri-lateral agreement involving the Alberta Medical Association, the Alberta Ministry of Health and Wellness and regional health authorities. The agreement also contains provisions to improve access to physician services. Under this agreement, ARPs have been established to enhance specialist physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction and value for money. ARPs provide predictable funding that enables physician groups to recruit new physicians to their programs and retain their services. ARPs are unique in that they offer alternatives to the way government has traditionally funded health service delivery.

Also under the agreement, family physicians can partner with their health regions to create Primary Care Networks that will manage 24-hour access to front-line services. Primary Care Networks use a team approach to coordinate care for their patients. Family physicians work with health regions to better integrate health services by linking to regional services such as home care. Family physicians also work with other health providers such as nurses, dieticians, pharmacists, physiotherapists and mental health workers who help to provide services within the Networks.

As with the majority of physicians, dentists performing oral surgical services insured under the Alberta Health Care Insurance Plan are compensated through the Plan on a volume driven, fee-for-service basis. The Ministry of Health and Wellness establishes fees through a consultation process with the Alberta Dental Association and College.

5.5 Payments to Hospitals

The *Regional Health Authorities Act* governs the funding of regional health authorities and provincial boards. Most insured hospital services in Alberta are funded through a population-based funding formula for regional health authorities. Regional health authorities also receive a mental health funding grant for insured services provided in mental health hospitals and for community mental health services. Capital Health and the Calgary Health Region receive funding to provide highly specialized province-wide services to all Alberta residents. The Alberta Cancer Board receives grant funding to provide insured services in cancer hospitals and to pay for cancer services that patients receive in regional hospitals. The regional health authorities and the Alberta Cancer Board are responsible for planning the allocation of funds for insured hospital services in accordance with regional needs assessments and health plans.

6.0 Recognition

The consolidated financial statements in the Ministry's annual report recognize the federal contributions provided under the Canada Health Transfer (CHT). The 2006/2007 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at:

http://www.health.alberta.ca/resources/AR07.html

7.0 Extended Health Care Services

Alberta also provides full or partial coverage for health care services not required by the *Canada Health Act*. They include: home care and long-term care; mental health services; dental, denturist and eyeglass benefits for recipients of the Alberta Widows' pension and their eligible dependants; palliative care; immunization programs for children; allied health services such as optometry (for residents under 19 and over 64 years), chiropractic and podiatry services; and drugs and other benefits through Alberta Blue Cross.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	3,124,487	3,165,157	3,210,035	3,275,931	3,384,625

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#):					
a. acute care	100	102	101	101	102
b. chronic care	110	107	106	103	98
c. rehabilitative care	1	1	1	1	1
d. other	3	3	3	3	3
e. total	214	213	211	208	204
3. Payments for insured health services ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	not available	not available	not available	not available [1]	not available [1]
b. diagnostic imaging facilities	not available	not available	not available	not available [1]	not available [1]
c. total	not available	not available	not available	not available [1]	not available [1]
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	4,275	4,651	4,550	4,508	4,608
7. Total payments, in-patient ($).	15,753,884	19,411,517	20,139,919	21,080,232	22,005,293
8. Total number of claims, out-patient (#).	67,975	68,469	72,495	77,438	82,710
9. Total payments, out-patient ($).	7,953,195	7,982,851	11,473,142	12,820,959	14,305,024
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	3,698	3,319	4,266	4,124	3,698
11. Total payments, in-patient ($).	340,169	300,233	381,217	379,710	336,859
12. Total number of claims, out-patient (#).	3,739	3,405	4,089	3,918	3,816
13. Total payments, out-patient ($).	206,684	212,949	227,609	222,896	224,761

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[1] These data are available from the College of Physicians and Surgeons of Alberta at http://www.cpsa.ab.ca/home/home.asp

Insured Physician Services Within Own Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	2,841	2,937	3,026	3,122	3,237
b. specialists	2,365	2,426	2,475	2,463	2,613
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	5,206	5,363	5,501	5,585	5,850
15. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	not available	not available	not available	not available	not available
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	29,328,923	30,044,400	31,683,660	33,428,098	34,031,123
b. total payments ($)	1,225,626,637	1,272,779,982	1,348,724,184	1,472,634,054	1,558,128,163

Insured Physician Services Provided to Residents in Another Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	559,503	485,841	444,884	479,029	463,410
20. Total payments ($).	13,880,981	15,139,409	15,871,755	17,745,928	17,450,377
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	21,289	20,753	26,017	24,944	22,909
22. Total payments ($).	976,232	963,299	1,208,422	1,049,384	1,054,544

Insured Surgical-Dental Services Within Own Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	234	216	216	230	220
24. Number of services provided (#).	16,759	14,802	14,658	17,007	16,783
25. Total payments ($).	2,394,458	2,404,042	2,843,638	3,275,978	3,637,243

British Columbia

Introduction

British Columbia has a progressive and integrated health system that includes insured services under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The British Columbia Ministry of Health has overall responsibility for ensuring quality, appropriate and timely health services are available to British Columbians. The Ministry works with six health authorities, care providers, agencies and other groups to provide access to care. The Ministry provides leadership, direction and support to service delivery partners and sets province-wide goals, standards and expectations for health service delivery by health authorities.

The Ministry directly manages a number of provincial programs and services. The directly managed programs include the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; and the Emergency Health Services Commission, which provides ambulance services across the province. The Ministry also operates health and information programs for British Columbians, including the BC HealthGuide and NurseLine program and the BC Vital Statistics Agency.

The province's six health authorities are the main organizations responsible for local health service delivery. Five regional health authorities are responsible for delivering a full continuum of health services to meet the needs of the population within their respective regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination and accessibility of selected province-wide health programs and services. This includes the specialized programs and services provided through the following agencies: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Provincial Renal Agency, BC Transplant Society, BC Women's Hospital & Health Centre, Forensic Psychiatric Services Commission, Provincial Cardiac Services and Riverview Hospital.

The delivery of health services and the health of the population are continuously monitored and evaluated by the Ministry. These activities inform the Ministry's strategic and policy direction to ensure the delivery of health services continues to meet the needs of British Columbians.

Activities for 2006–2007

In 2006–2007, the Government of British Columbia invested more than $12.1 billion to meet the health needs of British Columbians. This investment was made across a wide spectrum of programs and services aligned with the Ministry's goals to improve health and wellness, deliver high quality patient care, and make the publicly funded health system sustainable over the long term.

British Columbians enjoy some of the best health status in Canada. Nevertheless, nation-wide trends are creating unprecedented demands on the province's health system. Rising rates of obesity, a lack of physical activity, injuries, tobacco use and problematic substance use all affect the health status of individuals and increase demands for health services. In addition, the province's aging population is exhibiting a high incidence of chronic illness, resulting in increased demand for more complex and expensive health services.

Significant reforms and new initiatives have continued across the health system as the Ministry of Health worked with health authorities and health professionals to build a system that meets the needs of British Columbians and is sustainable into the future.

In 2006–2007, the Ministry introduced, continued or enhanced a number of strategies across the span of health services. These include: population health and safety; primary care; chronic disease management; Fair PharmaCare; ambulance services; community programs for mental health and addictions; hospital and surgical services; home care; assisted living; residential care; and end-of-life care. The Ministry also continued to ensure an adequate supply of skilled health providers is available to deliver services across the continuum of care.

B.C. also launched the Conversation on Health, an unprecedented, year-long discussion with and among British Columbians about how to strengthen and improve the province's health system. The Conversation invited British Columbians to send in their ideas, solutions and recommendations for the health system by email, website, letter, toll-free phone line, local MLA or by registering for one of a series of community meetings which took place in 16 communities between February and September 2007. The input gathered through the Conversation will be used to direct and inform British Columbia's development of health policies and initiatives to ensure the long-term sustainability of the B.C.'s publicly funded health system.

Significant Achievements in 2006–2007

Keeping People Healthy: In 2006–2007, the Ministry of Health introduced a number of health promotion and disease prevention initiatives designed to improve the health and wellness of British Columbians.

In 2006–2007, the Ministry:

- Launched *The First Nations Health Plan: Supporting the Health and Wellness of First Nations in British Columbia* in November of 2006 to outline B.C.'s commitment to close the gap in health status between First Nations and other British Columbians. Highlights include hiring an Aboriginal physician to advise on Aboriginal issues, improving access to primary health care services in Aboriginal health and healing centres, an Aboriginal Mental Health and Addictions Plan, and a new $8.5 million health centre in Lytton.
- Translated the BC HealthGuide into Chinese and Punjabi. More than 200,000 BC HealthGuides are being distributed in communities throughout the province with the assistance of many multicultural and community organizations, temples and providers of English language services for adults.
- Implemented early childhood screening programs for hearing, dental and vision health. The hearing and dental programs are underway and a phased-in program for vision screening has begun.
- Amended the *Tobacco Sales Act* to limit the promotion and sale of tobacco products and ban smoking in all indoor public places, including schools and on school grounds.
- Translated an emergency preparedness kit into Chinese, Punjabi, Vietnamese, Spanish and French to help non-English speaking British Columbians prepare for an influenza (flu) pandemic.

Increasing Access: Access has been expanded across the spectrum of care, from BC NurseLine services to heart surgery and cancer treatment.

In 2006–2007, the Ministry:

- Introduced a wait time reduction strategy focusing on hip/knee joint replacement, curative radiotherapy, sight restoration (cataract surgery), coronary artery bypass graft surgery and diagnostic services (mammography and cervical screening).

- Began development of a new Surgical Patient Registry to be operational by early 2008.
- Developed initiatives to help reduce congestion in emergency departments including working with teams of front-line professionals to generate innovative emergency department solutions for patients.
- Opened four $4.8m radiation therapy vaults at the Vancouver Cancer Centre that will improve access to an innovative treatment that delivers intense amounts of radiation to a very specific tumour target, while sparing the surrounding healthy tissue from radiation damage. More than 850 cancer patients a year will benefit from this increased system capacity.
- Expanded the Screening Mammography Program of BC and purchased a mobile screening unit. In January 2007, the program opened a new fixed location in Smithers, and now has 38 Centres and three mobile vans.
- Opened a $4.1 million Precision Radiotherapy Centre in Vancouver. The Centre can target cancers as small as one millimetre using new image-guided tools, and will provide services to approximately 600 patients each year.

Improving Quality of Health Services: In 2006–2007, a number of initiatives were undertaken across the health system to improve the quality of health services provided. Innovations, integrated services and the application of proven best practices in treating health conditions are leading to better health outcomes for British Columbians.

In 2006–2007, the Ministry:

- Granted $500,000 to the Heart and Stroke Foundation to launch an innovative Stroke Charter in emergency rooms across the province. The Charter will provide best practices for stroke prevention and management in emergency rooms throughout the province.
- Conducted the first ever provincial ambulatory oncology survey which showed 97.1 per cent of respondents felt the quality of their overall care was good, very good or excellent. Survey respondents were people who had received chemotherapy and/or radiation outpatient therapy in a B.C. facility in 2006.
- Reached labour agreements with the British Columbia Medical Association, British Columbia Nurses Union, Hospital Employees Union, Paramedical Professional Bargaining Association, Hospitalists and the Community Bargaining Association.
- Reached an agreement with the BC Medical Association to encourage physicians to implement electronic medical records. This will benefit patients through faster access to health information, improved patient safety and better co-ordination of care.
- Expanded PharmaNet to all authorized health professionals in hospitals and designated mental health facilities. PharmaNet is the province's secure electronic network that protects patients from potentially dangerous medication errors, duplications and dangerous combinations of different medications by linking prescriptions to a central database.

Investing for Future Sustainability: Making the right strategic investments now will ensure the health system is sustainable into the future. Investing in infrastructure and health human resources, independently or with funding partners, is a key priority for the government.

- Launched the *Conversation on Health*, an unprecedented, year-long discussion with and among British Columbians about how to strengthen and improve the province's health system. The *Conversation* invites British Columbians to send in their ideas, solutions and recommendations for the health system by email, website, letter, toll-free phone line, local MLA or by registering for one of a series of community meetings taking place in 16 communities between February and July 2007.

- The Province's $60.5 million wait time management strategy included $25 million for health authorities to immediately increase the number of surgeries with a focus on joint replacement surgery. The strategy also included $25 million for a new Centre for Surgical Innovation at UBC Hospital to support dedicated operating rooms to clear patient backlogs for hip and knee surgery.
- Continued to meet our targets to deliver 5,000 new residential care, assisted living and supportive housing units by the end of 2008. Through June 2007 we have built 3,411 net new beds. In total, we have built 8,839 new and replacement beds and units since 2001.
- Opened Cottonwood Lodge, a $5.5 million supportive, homelike environment for mental health patients in the Fraser Health Authority.
- Invested more than $40 million in March 2006 to expand UBC Clinical Academic Campuses at key teaching hospitals throughout British Columbia.
- Signed a $148-million contract with Sun Microsystems to advance patient care by building the infrastructure needed for electronic health records and improving access to laboratory test results. The program will enable physicians, nurses and other authorized caregivers involved in clinical practice to receive lab test results online.
- Invested an additional $26 million in B.C.'s Nursing Strategy. With this investment, the government has provided a total of $146 million since 2001 to help educate, retain and recruit the best qualified nurses in B.C.

Information on health and health services in British Columbia is available at:

www.gov.bc.ca/healthservices

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The British Columbia Medical Services Plan (MSP) is administered by the BC Ministry of Health; the Plan insures medically required services provided by physicians and supplementary health care practitioners, laboratory services and diagnostic procedures. The Ministry of Health sets province-wide goals, standards and performance agreements for health service delivery, and works together with BC's six health authorities to provide quality, appropriate and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); the *Continuing Care Act* (section 3); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages MSP on behalf of the Government of BC in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for BC, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function and mandate of the MSC is to facilitate, in the manner provided for in this Act, reasonable access throughout BC to quality medical care, health care and diagnostic facility services for residents of BC under MSP.

The MSC is a nine-member statutory body made up of three representatives from Government, three representatives from the British Columbia Medical Association (BCMA) and three members from the public jointly nominated by the BCMA and Government to represent MSP beneficiaries.

1.2 Reporting Relationship

The MSC is accountable to the Government of BC through the Minister of Health; a report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees and other delegated bodies. In addition, the MSC Financial Statement is published annually: it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals and diagnostic facilities for each fiscal year, and is available in September for the prior fiscal year.

The Ministry of Health provides extensive information in its Annual Service Plan Report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting, and is consistent with requirements contained in the province's *Budget Transparency and Accountability Act* (2000).

The Ministry of Health reports through various publications, including:

- Ministry Annual Service Plan Report;
- Report on Health Authority Performance (annual);
- Nationally Comparable Indictors Report; and
- Provincial Health Officer's Annual Report (on the health of the population).

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- The Office of the Comptroller General's Internal Audit and Advisory Services, the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry.
- The Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the audit recommendations.

1.4 Designated Agency

The Medical Service Plan (MSP) of BC requires premiums to be paid by eligible residents. The monies are collected by the Ministry of Small Business and Revenue.

Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance and collection, on behalf of the Province of British Columbia (Ministry of Small Business and Revenue). The Province remains responsible for, retains control of and performs all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:

- *Ombudsman Act* (British Columbia).
- *Business Practices and Consumer Protection Act* (British Columbia).
- *Financial Administration Act* (British Columbia).
- Freedom of Information Legislation: *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

The enabling legislation is:

- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8.
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums

Effective April 1, 2005, the Ministry of Health contracted with MAXIMUS BC to deliver the operations of the Medical Services Plan and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). This new organization is called Health Insurance BC. Policy and decision-making functions remain with the Ministry of Health.

- The contract with Maximus BC is enabled through the Medical Services Commission (MSC is empowered to manage MSP on behalf of the Government of BC).
- Health Insurance BC submits monthly reports to the Ministry of Health, reporting performance on service levels to the public and health care providers.
- Health Insurance BC posts quarterly reports on its website on performance on key service levels.
- Health Insurance BC applies payments against fee items approved by the Ministry of Health. The Ministry approves all payments before they are released.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister to designate facilities as hospitals, to license private hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* provides the authority for the Minister to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

There were no legislative or regulatory amendments made to the *Hospital Act* or *Hospital Insurance Act* or their regulations in 2006–2007.

In 2006–2007, there were a total of 139 facilities designated as hospitals. This included:

- 82 acute care hospitals (community hospitals, large tertiary care and teaching hospitals);
- 18 chronic care hospitals;
- 4 rehabilitation hospitals; and
- 35 other hospitals (including diagnostic and treatment centres, free-standing abortion clinics, cancer clinics, etc.)

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital, and are deemed medically required by the attending physician, nurse practitioner or midwife. These services are provided to beneficiaries without charge, with the exception of incremental charges for preferred, but not medically required medical/surgical supplies, non-standard accommodation when not medically required, and for residential care patients in extended care or general hospitals, a daily fee based on income.

General hospital services, and the conditions under which they are provided, are described in the Hospital Insurance Act Regulations, division 5, and include the following for inpatients: accommodation and meals at the standard or public ward level; necessary nursing services; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; drugs, biologicals and related preparations; routine surgical supplies; use of operating room and case room and anaesthetic facilities, including necessary equipment and supplies; use of radiotherapy and physiotherapy facilities, where available; and other services approved by the Minister.

The following out-patient general hospital services are also insured: day care surgical services; out-patient renal dialysis treatments in designated hospitals or other approved facilities; diabetic day-care services in designated hospitals; out-patient dietetic counselling services at hospitals with qualified staff dieticians; psychiatric out-patient and day-care services; rehabilitation out-patient services; cancer therapy and cytology services; out-patient psoriasis treatment; abortion services; and MRI services.

Insured services in rehabilitation hospitals include: accommodation and meals at the standard or public ward level; necessary nursing services; drugs, biologicals and related preparations; use of physiotherapy and occupational therapy facilities; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; and other services approved by the Minister.

Insured services in extended care hospitals include: accommodation and meals at the standard ward level; necessary nursing service; drugs, biologicals, and related preparations; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; and other services approved by the Minister.

Insured hospital services do not include: transportation to and from hospital (however, ambulance transfers are insured under another Ministry of Health program, with a small user charge); services provided to non-beneficiaries (with the exception of emergency treatment); services or treatment that the Minister, or a person designated by the Minister, determines, on a review of the medical evidence, the beneficiary does not require; and services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council.

No new hospital services were added during the fiscal year.

There is no regular process to review insured hospital services, as the list of insured services included in the regulations is intended to be both comprehensive and generic and does not require routine review and updating. There is a formal process to add specific medical services (physician fee items) to the list of services insured under the *Medicare Protection Act*, but this process is described elsewhere.

2.2 Insured Physician Services

The range of insured physician services covered by MSP includes all medically necessary diagnostic and treatment services.

Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care practitioners, such as midwives) who are enrolled and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as Medical Services Plan (MSP) benefits under the MPA in accordance with the *Canada Health Act*:

- medically required services provided to "beneficiaries" (residents of British Columbia) by a medical practitioner enrolled with MSP; and
- medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In fiscal year 2006–2007, 8,626 physicians (includes only GPs and Medical

Specialists who billed fee-for-service [FFS] in 2006–2007) were enrolled with MSP and billed fee-for-service. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) to the health authorities. Physicians paid by these alternative mechanisms may also practice on a fee-for-service basis.

Non-physician healthcare practitioners who can be enrolled to provide insured services under MSP are midwives and supplementary benefit practitioners (dental surgeons, optometrists, podiatrists). Only those MSP beneficiaries with premium assistance status qualify for MSP coverage of physiotherapy, massage therapy, chiropractic, naturopathy and non-surgical podiatry services. In 2006–2007 there were 13,136 practitioners paid FFS through MSP.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission (MSC). Enrolled physicians may cancel their enrolment by giving 30 days' written notice to the Commission. Patients are responsible for the full cost of services provided by non-enrolled physicians. The Medical Services Plan of BC currently has five opted-out physicians and one de-enrolled physician.

Enrolled physicians can elect to be paid directly by patients by giving written notice to the Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered.

During fiscal year 2006–2007 physician services which were added as MSP insured benefits included fee items which reflect current practice standards, for example: new fee items for pædiatric case conferences, laser lead extraction, cytogenic analysis by fluorescence in situ hybridization (FISH); fee items to track immunizations; revised fee items for methadone treatments, laparoscopic splenectomy and anæsthetic administration for cataract surgery; and an updated laboratory medicine payment schedule, including laboratory and volume discounting. In addition, fee items were added to encourage general practitioners to return to hospital work by obtaining admitting privileges.

Under the Master Agreement between the government, MSC and the British Columbia Medical Association (BCMA), modifications to the payment Schedule such as additions, deletions or fee changes are made by the Commission, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time while definitive listings are established.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by MSP when hospitalization is medically required for the safe and proper completion of surgery, and when they are listed in the Dental Payment Schedule. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the Medical Services Commission. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction.

Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan may provide insured surgical-dental services in hospital. There were 234 dentists (includes only Oral Surgeons, Dental Surgeons, Oral Medicine and Orthodontists who billed fee-for-service in 2006–2007) enrolled with the Medical Services Plan and billing fee-for-service in 2006–2007. None have de-enrolled or opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial PharmaCare program. Other procedures not insured under the *Hospital Insurance Act* include: services of medical personnel not employed by the hospital; treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible; services solely for the alteration of appearance; and reversal of sterilization procedures.

Uninsured hospital services also include: preferred accommodation at the patient's request; televisions, telephones and private nursing services; preferred medical/surgical supplies; dental care that could be provided in a dental office including prosthetic and orthodontic services; and preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan include: those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; acupuncture; telephone advice unrelated to insured visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

The *Medicare Protection Act*, (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit". The Ministry of Health responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the BCMA's Tariff Committee. No services were de-listed in 2006–2007.

3.0 Universality

3.1 Eligibility

Section 7 of the *Medicare Protection Act* defines the eligibility and enrolment of beneficiaries for insured services. Part 2 of the Medical and Health Care Services Regulation made under the *Medicare Protection Act* details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits.

The *Medicare Protection Act*, in section 1, defines a resident as a person who:

- is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- makes his or her home in British Columbia;
- is physically present in British Columbia at least 6 months in a calendar year; and
- is deemed under the regulations to be a resident.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see section 3.3 below), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in BC are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of

July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces, appointed members of the Royal Canadian Mounted Police, or serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance.

The Medical Services Plan (MSP) provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

Residents must be enrolled in the Medical Services Plan (MSP) to receive insured hospital and physician services. Those who are eligible for coverage are required to enrol. Once enrolled, beneficiaries are assigned a unique Personal Health Number and issued a CareCard. There is no expiration date on the card. New residents are advised to make application immediately upon arrival in the province.

Beneficiaries may cover their dependents, provided the dependents are residents of the province. Dependents include a spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward supported by the beneficiary, and either under the age of 19 or under the age of 25 and in fulltime attendance at a school or university.

The number of MSP registrants in 2006–2007 was 4,279,734. Enrollment in MSP is mandatory, in accordance with the *Medicare Protection Act* (section 7). Only those adults who formally opt out of all provincial health care programs are exempt. A beneficiary who wishes to opt out of MSP can do so by completion and submission of the appropriate Election to Opt Out (ETOO) form. The term of this decision is 12 months from the first of the month of receipt of the application, after which each adult must re-apply to remain opted out of MSP.

3.3 Other Categories of Individual

Holders of Minister's Permits, Temporary Resident Permits, study permits, and work permits are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section 2 of the Medical and Health Care Services Regulation.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for the Medical Services Plan are $54 for one person, $96 for a family of two, and $108 for a family of three or more.

Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or holder of permanent resident (landed immigrant) status under the *Immigration and Refugee Protection Act* (Federal)

4.0 Portability

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in BC are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage During Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulation of the *Medicare Protection Act* define portability provisions for persons temporarily absent from BC with regard to insured services. In 2006–2007, there were no amendments to the Medical and Health Care Services Regulation with respect to the portability provisions

Individuals who leave the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 months. Approval is limited to once in five years for absences that exceed six months in a calendar year. Residents who spend part of every year outside BC must be physically present in Canada at least six months in a calendar year and continue to maintain their home in BC in order to retain coverage. When a beneficiary stays outside BC longer than the approved period, they will be required to fulfill a waiting period upon returning to the province before coverage can be renewed. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible BC residents, on presentation of a valid MSP Card (CareCard). BC then reimburses the province or territory, at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the inter-provincial and inter-territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though inter-provincial and inter-territorial reciprocal billing procedures. In 2006–2007, the amount paid to physicians in other provinces and territories was $26.9 million. Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to BC beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec or outside of Canada, the beneficiary will probably be required to pay for medical services and seek reimbursement later from MSP.

BC pays host provincial rates for insured services according to the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, s. 24; the *Hospital Insurance Act* Regulations, Division 6; the *Medicare Protection Act*, s. 51; and the Medical and Health Care Service Regulation, ss. 3, 4, 5. The Medical and Health Care Services Regulation was amended by BC Reg. 111/2005. These changes were effective March 18, 2005.

The relevant issues addressed by the amendments are as follows:

- All provinces, except Quebec, have eliminated caps on MSP coverage for students studying abroad, enabling them to finish their undergraduate and graduate studies. The amendment brings BC in line with other provinces and removes the 60-month cap for full-time students studying abroad at an educational institution. The students must be enrolled in and attending the institution.

- Because of increasing demand for a specialized and mobile work force employed for short-term contracts and assignments, many provinces have extended health insurance coverage to 24 months of absence. British Columbians were deemed residents for the first 12 months of absence. This amendment extends coverage to 24 months; approval is limited to once in five years for absences that exceed six months in a calendar year. This brings BC in line with practice in other provinces.
- BC residents who are temporarily absent from BC and cannot return due to extenuating health circumstances are deemed residents for an additional 12 months if they are visiting in Canada or abroad. This amendment also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the inter-provincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements.

Physician services excluded under the Inter-Provincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims: surgery for alteration of appearance (cosmetic surgery); gender-reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies; RCMP, Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries); services requested by a "Third Party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the BC physician.

Some treatments (e.g., treatment for anorexia) may require the approval of the Health Authorities Division of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the Commission before the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

Beneficiaries in BC, as defined in section 1 of the *Medicare Protection Act*, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

Nurses comprise the largest group of professional staff within the health care sector. The number of Registered Nurses licensed to practice in British Columbia (BC) as of December 2006 was 31,960. BC hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2006, there were 2,173 RPNs and 5,940 LPNs licensed to practice in the province.

In 2006/07, the BC government provided additional funding to build on successful recruitment, retention and education nursing strategies. This funding brought the government's total commitment to nursing strategies to $146 million since 2001. British Columbia's nursing strategies are developed and implemented annually by the Ministry of Health's Nursing Directorate through consultation with stakeholders, input from the Nursing Advisory Committee of British Columbia, and a review of national trends and policies. The following priorities form the broad strategy framework:

- human resources planning for recruitment, retention and education of nurses in BC to address health care needs;
- enhancing nursing practice environments by supporting health authorities and government to make sound nursing policy in keeping with current research and provincial, national and global trends;
- analyzing nursing data to enhance the Ministry's understanding of trends and changing needs in nursing and health care;
- recruiting students of aboriginal descent into nursing, supporting those already in nursing programs, and recruiting/retaining aboriginal nurses currently practising in BC; and,
- promoting nursing as a career of choice to ensure the future of a quality British Columbia health care system.

Some of the programs funded in 2006–2007 included: expansion of recruitment initiatives for internationally educated nurses, aboriginal nursing strategies, internship/new graduate transition program, operating room initiative for LPNs, post-basic acute rural nursing education program and expansion of Nurse Practitioner (NP) implementation. In addition, the Ministry of Health has partnered with the Ministry of Advanced Education to work closely with educational institutions to increase nursing education spaces.

On August 19, 2005, the Nurses (Registered) and Nurse Practitioners Regulation came into effect. The regulation established the new College of Registered Nurses of British Columbia under the *Health Professions Act* as the regulatory body for Registered Nurses and also enables NPs to be regulated by the new College and to practice in British Columbia. In BC, NPs are Master's-prepared or have equivalent clinical experience and education. The first BC educated NPs graduated in 2005, and NP programs are currently being offered at the University of British Columbia, the University of Victoria, and the University of Northern BC. Due to the overwhelming success of NP integration in the province, BC has expanded the implementation of the role of NPs in both urban and rural settings.

In recent years, the Province of British Columbia has initiated changes that encourage strategic investment in capital infrastructure and innovative approaches to meeting health service delivery needs, now and in future.

The Ministry of Health has introduced a longer capital planning cycle and has gathered better data on current capital assets to support improved decision-making and better forecasting of needs. The Ministry is now working to extend the capital planning horizon to extend to capital planning to coincide with longer-term acute care and complex care planning which is particularly beneficial in planning for major infrastructure such as hospitals that have life-cycles encompassing several decades. It also gives the health authorities more time to explore creative ways of addressing capital requirements.

The Province committed $42.5 million for the expansion and upgrading of academic space in teaching hospitals around BC to support increased enrolment of medical students.

The *2003 First Ministers' Accord on Health Care Renewal* established a $1.5 billion national diagnostic and medical equipment fund, of which $200.1 million was apportioned to British Columbia, over three years. Health authorities spent this fund on a wide variety of equipment for diagnostic/therapeutic and medical/surgical purposes, and to enhance comfort and safety for patients and staff.

The province invested $35 million in leading-edge medical technologies, using $25 million of the federal funding as well as provincial capital and foundation dollars. A committee of representatives from the Ministry of Health, the health authorities and various health care fields provided expertise and advice in identifying investments to improve patient access and most strategically serve the needs of British Columbians.

The funding was used by health authorities for equipment such as:

- the province's first publicly funded PET unit located at the Vancouver Cancer Agency, which will improve the management of cancer patients by providing accurate pre-treatment detection of cancerous tumors and monitoring therapy response to improve recovery;
- new CT scanners in the Lower Mainland and Victoria that will improve cardiac care in BC and increase provincial capacity for diagnosing heart and brain disease as well as handling trauma cases;
- a mobile MRI scanner for the Kootenays and South Okanagan and a CT scanner at Kelowna that will significantly improve access for patients with wide ranging needs in the province's interior regions; and
- a Picture Archiving Communication System and a Radiology Information System for the Northern Health Authority that will enhance access to care and treatment in many small communities by allowing sharing of digital images between hospitals/regions and radiologists across the north.

The *September 2004 First Ministers' Agreement* committed an additional $66 million in Medical Equipment funding for BC to be spent by 2007–2008

BC HealthGuide Handbook: A free 400+ page handbook that covers over 200 health topics and includes information on how to recognize and manage common health concerns; tips on home treatment; care options; and when to see a doctor. The handbook was delivered free to every household in British Columbia in spring 2001. The updated version, published in November 2005, is available free of charge to all British Columbians at Government Agents Offices and local pharmacies. The updated handbook contains new information on seniors' health, including healthy aging and tips for caregivers.

A BC First Nations Health Handbook, developed in partnership with the BC First Nations Chiefs' Health Committee, was released in June 2003 and a French version, Guide-santé — Colombie-Britannique, was released in June 2004. Translated and culturally focused versions in Chinese and Punjabi will be available in April 2007.

BC HealthGuide OnLine: A comprehensive public website (www.bchealthguide.org) with current, medically approved information on over 3,000 health topics, tests, procedures and resources. The website expands on the information in the BC HealthGuide handbook with more than 35,000 medically reviewed pages covering over 3,000 health topics. BC HealthGuide OnLine provides information on the BC HealthGuide Program components in French, Chinese, Punjabi and Farsi. Annual hits (page views) to the BC HealthGuide OnLine have more than tripled since implementation in 2002 with over 30.5 million hits in 2006–2007.

BC NurseLine: A 24-hour, toll-free contact centre service providing access to registered nurses specially trained to provide confidential health information and advice on the telephone. Registered nurses are specially trained to use medically approved protocols to provide confidential health information and advice on acute and chronic health symptoms and conditions and when to see a health professional. Health information and advice is available in over 130 languages to anyone in British Columbia with access to a telephone.

Over 1.57 million calls have been received by the BC NurseLine since the programs launched in 2001. Specifically in 2006–2007, the BC NurseLine received over 347,241 calls.

In June 2003 the BC NurseLine was enhanced to include a pharmacist referral service. Between 5 p.m. and 9 a.m. daily, registered nurses of BC NurseLine can refer callers direct to a pharmacist to answer medication-related calls. The pharmacist service has received over 40,518 medication related calls transferred from the BC NurseLine. Over this period, BC NurseLine pharmacists submitted 834 Adverse Drug Reaction (ADRs) reports to the British Columbia/Yukon Regional ADR Centre. 803 of these ADRs have been approved for submission to Health Canada, Canadian ADR Monitoring Program. These reports are used to monitor adverse effects that are unexpected, serious or for newly marketed medications. The pharmacist service is responsible for 35 percent of all ADR reports submitted to the British Columbia/Yukon Regional ADR Centre, making it a large and integral contributor to patient safety in British Columbia.

BC HealthFiles: A series of over 200 easy-to-understand fact sheets with British Columbia-specific information on a wide range of public and environmental health and safety topics. Translated versions of a number of the BC HealthFiles are available. Fact sheets are available to residents and as a resource to health care professionals by download from the BC HealthGuide OnLine website and from public health units.

Launched in January 2005, the BC NurseLine provides after-hours triage and support to Hospice Palliative Care (HPC) patients in the Fraser Health Authority. HPC patients are able to contact the BC NurseLine for after-hours support from 9 p.m. to 8 a.m.

From September 2005 to March 2006, the BC NurseLine in partnership with Fraser Health Authority and Northern Health Authority launched the demonstration phase of the Chronic Disease Management (CDM) Project. The Project provides primary health care teams with an opportunity to refer patients with diabetes or congestive heart failure with self-management support. Those patients with complex medication issues are referred by the BC NurseLine to a pharmacist coach. The effectiveness of the demonstration phase of the CDM Project will be evaluated and leveraging the CDM Project as part of the existing CDM support available in BC will be considered.

From July 2006 to December 2006, the BC NurseLine and Interior Health Authority piloted a telehomecare monitoring project in the East Kootenays to determine the effectiveness of expanding the project across the authority. Congestive heart failure patients used monitoring equipment set up in their home to record their vitals daily. The information was then securely transferred to a central monitoring station. The information was monitored by a registered nurse, in the Interior Health Authority on weekdays and BC NurseLine on weekends, who would follow up with the patient as required based on the vitals that were recorded.

Dial-A-Dietitian: A free nutrition information service that provides easy-to-use nutrition information for self-care, based on current scientific sources, by a registered dietitian over the telephone. Registered dietitians are available 9:00am to 5:00pm, Monday to Friday. Referrals are provided to hospital outpatient dietitians, community nutritionists and other local services. Translation services are available in over 130 languages.

In addition to nutrition information over the telephone, the Dial-A-Dietitian service includes a comprehensive website (www.dialadietitian.org) with nutritional information and useful links.

In March 2005, Dial-A-Dietitian added an Allergy Dietitian to team to answer questions about food allergies and intolerances and in February 2007, an Oncology Dietitian was added to answer questions and provide information to individuals who are interested in preventing cancer, or have been diagnosed and/or are recovering from cancer. In 2006–07 Dial-A-Dietitian received 22,553 calls.

The Ministry's 2004–2005 to 2006–2007 Service Plan contained a number of objectives and strategies designed to reach the Province's goals for a sustainable health system.

This includes Priority Strategy 3: Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services. While most of the strategies under this objective focus on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high-quality manner. Under this strategy, the Ministry and all five health authorities have participated in two province-wide projects to improve access to, and effectiveness of, emergency room and surgical services in hospitals across the province.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2006–2007, approximately 2,653 general practitioners and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP).

APP funds regional health authorities to hire salaried physicians or contract with physicians, in order to deliver insured clinical services.

The Ministry of Health implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia.

These programs include:

- the Rural Retention Program, provides eligible physicians (estimated at 1,300) with fee premiums and is available for resident, visiting physicians and locums and also provides a flat fee sum for eligible physicians who reside and practice in a rural community;
- the Northern and Isolation Travel Assistance Outreach Program, which funded an estimated 2,002 visits by family doctors and specialists to rural communities;
- the Rural General Practitioner Locum Program, which assisted physicians in approximately 64 small communities to attend continuing medical education and provided vacation relief;
- the Rural Specialist Locum Program, which provided locum support for core specialists in 15 rural communities to provide vacation relief and while physician recruitment efforts were underway;
- the Rural Education Action Plan, which supported training physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practicing physicians;
- the Isolation Allowance Fund, which provided funding to communities with fewer than four physicians and no hospital, and where Medical On-call/Availability Program, call-back, or Doctor of the Day payments are not available; and
- the Rural Loan Forgiveness Program, which decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives and pharmacists.

The Full-Service Family Practice Incentive Program has recently been expanded through the 2007 agreement with physicians and the ministry continues to establish clinical practice guidelines and protocols to improve patient care.

The University of British Columbia's (UBC) medical school is expanding in collaboration with the University of Northern British Columbia, the University of Victoria and British Columbia's health authorities to double the number of medical students. In 2002, the government announced $134 million to build a new Life Sciences Centre at UBC in Vancouver and other distributed sites for medical programs in Prince George and Victoria.

British Columbia's annual intake for medical students was 128 in 2003. The expanded program doubled the number of first-year seats to 256 in 2007.

In addition, British Columbia is planning to further expand the medical program to B.C.'s southern Interior, adding another 32 first-year medical school spaces to the province's medical program.

In addition to the medical school expansion, the Ministry of Health has begun to expand post-graduate medical education (residency positions) to keep pace with undergraduate MD program growth. In 2003, the Ministry funded 128 entry-level residency positions for Canadian medical graduates (CMGs). Since July 2003, this has increased by 96 to 224 entry-level positions. With the further expansion of medical education to the province's southern Interior, postgraduate medical education is expected to increase to 288 entry-level residency positions for CMGs.

5.4 Physician Compensation

The Province of British Columbia (BC) negotiates with the BC Medical Association (BCMA) to establish the conditions, benefits and overall compensation for physicians.

The BCMA has the sole and exclusive right to represent the interests of physicians who receive funding for their services from the government. Membership in the BCMA is not mandatory.

Funding for physicians accounted for over $2.87 billion or 24 percent of the Ministry of Health budget in 2006–2007.

The BC government and the BCMA entered into a Master Agreement governing the relationship between the province and the provinces' physicians, effective December 1993, for a term which was extended to March 31, 2001. The parties entered into the Second Master Agreement February 28, 2001, which was set to expire Midnight March 31, 2006. The April 1, 2004 Working Agreement, which was due to expire March 31, 2007, had a re-opener clause for March 31 2006 to allow for negotiations on rates of compensation for fiscal year 2006/07. Negotiations between the BCMA and the government resulted in the 2006 Agreement and an Amended Second Master Agreement. The 2006 Agreement, terms of which expire April 1, 2012, addresses matters of financial interest to all physicians while subsidiary agreements address matters of unique interest to a particular group of physicians.

Under the 2006 Agreement, there were generalized increases in compensation rates: in 2006/07 there was 2.8 percent increase awarded, in 2007/08 there was a 2 percent increase, in 2008/09 a 2 percent increase was agreed, in 2009/10 a 3 percent increase has been approved. There will be a financial re-opener for 2010/11/12. Sessional agreements were adjusted by 5.5 percent in the first year and incentives and targeted funding were included in the Agreement to bring the total increase by 2010 to about 19 percent.

The Working Agreement included some elements of system redesign and renewal which included: a review of the Medical On-Call/Availability Program, support for improved access to specialist services; support for patient access and improvement to full service family practice, enabling shared care and appropriate scopes of practice among general practitioners, specialist physicians and other health care professionals; expansion of funding of alternative payment plans; a review of the work of the Joint Standing Committee on Rural Issues to improve the accessibility of health care to rural British Columbians; and the use of electronic technology in physician practice to support patient care.

Physician benefits were also improved under the Working Agreement and the 2006 Agreement and included increased benefits to the Contributory Professional Retirement Savings Plan Agreement and changes in the physicians Pregnancy Leave program.

The 2006 Agreement requires the parties to develop a Physician Master Agreement and Subsidiary Agreements by February 28 2007. If, by that date, the parties have not agreed upon the terms of a Physician Master Agreement and master Subsidiary Agreements then a conciliator will be asked to issue a report identifying outstanding issues. The conciliator was asked to begin working with the parties in the winter of 2006.

The parties agreed that the Amended Second Master Agreement remains in effect after March 31, 2007 or until replaced by the Physician Master Agreement and Master Subsidiary Agreements. The Physician Master Agreement is to expire on March 31 2012, and is intended to structure the relationship between government and the BCMA, and replace all previous Agreements with this new structure. The levels of compensation, terms and conditions of payments, fee for service, sessional, contract and salary increases agreed to in the 2006 Working Agreements and/or Subsidiary Agreements will remain in place. The Physician Master Agreement is also intended to establish conflict resolution processes that will create a framework, using experts in mediation and arbitration, in which both rights and interest disputes can be resolved in a manner that reduces the impact on patients.

The government has approached negotiations with physicians in a spirit of collaboration and with the interest of quality care for patients as the foremost concern. Negotiations for changes to the Second Master Agreement and for compensation increases for 2006–2007 began in 2005, using a principle-based approach. A tentative Agreement in Principle was reached in March 2006 and was ratified in May 2006, covering the period from 2006 to 2012. The 2006 Agreement facilitates coordination with health authorities and provides for their participation on committees, enhancing coordination of patient care services in cooperation with the BCMA and the Ministry of Health. The agreements continue to compensate physicians for direct patient care. The agreement also included reform initiatives such as enhancement of full-service family practice as well as enhanced recruitment and retention of physicians in the most rural communities and of specialists where there is a current or anticipated problem.

With respect to dentists, the BC government negotiates with the Dental Association of BC. The previous formal negotiation process led to an updated and modernized contract which expired. The parties are currently operating under a Memorandum of Understanding regarding funding. The Dental Association of BC has requested renegotiation of a new contract to commence in the spring of 2007.

Legislation

The *Medicare Protection Act*, RSBC 1996, c. 286, provides the authority for the Medical Services Commission to administer the Medical Services Plan of British Columbia. There were no significant amendments of the Act or regulations in 2006–2007.

Medical practitioners are licensed under the *Medical Practitioners Act* and dentists under the *Dentists Act*.

Compensation Methods for Physicians and Dentists

Payment for medical services delivered in the Province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payments Program to health authorities for contracted physicians' services. Over 90 percent of payments were distributed as fee-for-service payments and nearly 10 percent were distributed as alternate payments. Of the alternate payments, 63.5 percent are distributed through contracts, 26.3 percent as sessions (3.5-hour units of service), 4.5 percent as salaried arrangements and 5.7 percent for capitation. The government funds health authorities for alternative payments, but does not pay physicians directly.

Payment for dental services delivered in the province is made through the Medical Services Plan totally on a fee-for-service basis.

5.5 Payments to Hospitals

Funding for hospital services is included in the annual funding allocation and payments made to regional health authorities. This funding allocation is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of BC), including the provision of hospital services.

While the hospitals portion of the funding allocation is normally not specified, the exception to this rule is funding targeted for specific priority projects (e.g., reduction in wait times for hips and knees). For these initiatives, funding is specifically earmarked, and must be reported on separately.

Annual funding allocations to health authorities are determined as part of the Ministry of Health's annual budget process in consultation with the Ministry of Finance and Treasury Board. The final funding amount is conveyed to health authorities by means of an annual funding letter.

The accountability mechanisms associated with government funding for hospitals is part of several comprehensive documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual Government Letters of Expectations. Taken together, these documents convey the Ministry of Health's broad expectations for health authorities, and explain how performance in relation to these expectations will be monitored.

The *Hospital Insurance Act* and its related regulations govern payments made by the health care plan to health authorities. This statute establishes the authority of the Minister to make payments to hospitals, and specifies in broad terms what services are insured when provided within a hospital.

No amendments were made during 2006–2007 to legislation or regulations concerning payments for insured hospital services.

Insured hospital services are included within the annual funding allocations to regional health authorities, as well as specific targeted funding from time to time. Incremental funding is allocated to health authorities using the Ministry of Health's Population Needs-Based Funding formula and other funding allocation methodologies (to reflect specific program delivery requirements within health authorities).

A total of $7.1 billion was allocated to health authorities in 2006–2007 to provide the full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions programs, etc.).

The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry of Health, such as the payments to physicians, payments for prescription drugs covered under PharmaCare, or for provincial ambulance services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents.

In 2006–2007, these documents included:

- Public Accounts 2005–2006 (tabled July 17, 2006) www.fin.gov.bc.ca/ocg/pa/05_06/pa05_06.htm
- Budget and Fiscal Plan, 2006–2007 to 2008–2009 (tabled February 21, 2006) www.bcbudget.gov.bc.ca/2006/bfp/default.htm

- Estimates, Fiscal Year Ending March 31, 2007 (tabled February 21, 2006)
- www.bcbudget.gov.bc.ca/2006/est/Estimates_06a.pdf

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care Services

Residential care facilities provide 24-hour professional nursing care and supervision in a protective, supportive environment for adults who have complex care needs and can no longer be cared for in their own homes.

Residential care clients pay a daily fee based on their after-tax income. Rates are adjusted annually based on the Consumer Price Index. The legislation pertaining to residential care facilities is the *Community Care and Assisted Living Act*, the Adult Care Regulations, the *Hospital Act*, the Hospital Act Regulation, the *Hospital Insurance Act*, the Hospital Insurance Act Regulations, and the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Family care homes are single family residences that provide meals, housekeeping services and assistance with daily activities for up to two clients. The cost for family care homes is the same as for residential care facilities.

The legislation pertaining to family care homes is the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Adults with disabilities can also live independently in the community in publicly funded group homes. Group homes are safe, affordable, four-bed to six-bed housing projects. They offer short- and long-term accommodation, skills training, peer support and counselling. Group home clients are responsible for living costs, such as food and rent, not associated with their care. Rental costs vary, depending on income. The legislation pertaining to group homes is the *Community Care and Assisted Living Act*, the Adult Care Regulations, *Continuing Care Act* and the Continuing Care Programs Regulation.

Assisted living residences provide housing, hospitality and personal assistance services for adults who can live independently, but require regular assistance with daily activities, usually because of age, illness or disabilities. Residences typically consist of one-bedroom apartments.

Services include help with bathing, grooming, dressing or mobility. Meals, housekeeping, laundry, social and recreational opportunities and a 24-hour response system are also provided. Clients pay a monthly charge based on 70 percent of their after-tax income, up to a maximum of a combination of the average market rent for housing and hospitality in a particular geographic area and the actual cost of personal care. The legislation pertaining to assisted living residences is the *Community Care and Assisted Living Act*, the Assisted Living Regulation, the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Hospice services provide a residential home-like setting where supportive and professional care services are provided to British Columbians of any age who are in the end stages of a terminal illness or are preparing for death. Services may include medical and nursing care, advance care planning, pain and symptom management, and psychosocial, spiritual and bereavement support. There may be a charge for some hospice services. The legislation pertaining to hospices is the *Community Care and Assisted Living Act*, the Adult Care Regulations, the *Hospital Act* and the Hospital Act Regulation.

Services for Persons with Mental Illness and Substance Use Disorders

There are three distinct types of housing and programs for people with severe mental illness and or substance use disorders: Community Residential Care Facilities; Family Care Homes; and Supported Housing.

Community Residential Care Facilities

These facilities provide 24-hour care, intensive treatment and support services, including psychosocial rehabilitation, such as assistance with personal care, home/money management, socialization, medication administration and linking with external services such as supported education and supported employment programs. For some residents, community residential care is a "stepping stone" towards more independent housing while for others their stay is long-term. All facilities are licensed under the *Community Care and Assisted Living Act*. Clients pay a standard daily fee based on income for room and board.

Family Care Homes

These private homes, operated by families or individuals, provide basic living skills and psychosocial rehabilitation services for clients unable to live independently, who require support within a family setting to acquire the skills and confidence necessary for independent living. Homes are not licensed or registered but must meet standards set out by the health authority. Clients pay a standard daily fee based on income for room and board.

Supported Housing

Supported housing programs include affordable, safe and secure accommodation and the availability of a range of psychosocial rehabilitation and home support services, such as assistance with meal preparation, personal care, home management, medication support, socialization, and crises management.

Supported Housing programs include: supported apartments, block apartments, congregate housing; group homes and low barrier housing. Clients pay reduced rent base on income.

Home Care Services

Home care nursing and community rehabilitation services are professional services, delivered to people of all ages by registered nurses and rehabilitation therapists. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination and direct care or treatment for clients with chronic, acute, palliative or rehabilitative needs. There is no charge for these services.

Home support services help clients remain in their own homes. Home support workers provide personal assistance with daily activities, such as bathing, dressing, grooming and, in some cases, light household tasks that help maintain a safe and supportive home. Depending on an individual's income, there may be a cost associated with home support services. The legislation pertaining to home support services is the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

End-of-life care preserves clients' comfort, dignity and quality of life by relieving or controlling symptoms so those facing death, and their loved ones, can devote their energies to embracing the time they have together.

Professional care givers and support staff provide supportive and compassionate care in the client's home, in hospital, hospice, an assisted living residence or a residential care facility. Depending on the type of care required and an individual's income, there may be a cost associated with some services.

A Palliative Care Benefits Program was implemented in 2001 to provide people living at home who are nearing the end of their life with approved medications for pain or symptom relief and some medical supplies and equipment, at no charge. Approved medications can be obtained through a local pharmacy.

Ambulatory Health Care Services

Adult day programs assist seniors and adults with disabilities to be independent. They provide supportive group programs and activities that give clients a chance to be more involved in their community and offer care providers a break. Services vary with each centre, but may include personal care, social activities, meals and transportation.

Centres usually charge a small daily fee to assist with the cost of craft supplies, transportation and meals. The legislation pertaining to adult day programs is the *Continuing Care Act* and the Continuing Care Programs Regulation.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	4,017,912	4,099,076	4,182,682	4,216,199	4,279,734

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#): [1]					
a. acute care	92	92	92	82	82
b. chronic care	18	18	18	19	18
c. rehabilitative care	3	3	4	4	4
d. other	25	24	23	32	35
e. total	138	137	137	137	139
3. Payments for insured health services ($): [2]					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	1	11	17	18	22
b. diagnostic imaging facilities	not available	0	1	1	0
c. total	1	11	18	19	22
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	358,600	1,470,370	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	358,600	1,470,370	not available	not available	not available

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For items 1–2: Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

1. In British Columbia, the categories under which these facilities are reported in this Health Act report table do not match those normally used in the BC Ministry of Health, but facilities have been matched to this report's specifications as closely as possible.

   — Acute Care includes only acute care inpatient facilities from 2005/06 onward. In previous years this category also included acute care ambulatory facilities and one psychiatric inpatient facility (both now counted under "Other").

   — Chronic Care includes extended care facilities. The one additional facility in 2005/06 is not a new facility. In the past, statistics for this facility were reported as part of a larger group of facilities, but are now reported separately.

   — Rehabilitative care includes rehabilitation facilities.

   — Other includes acute care ambulatory care facilities, diagnostic and treatment centres and one inpatient pyschiatric inpatient facility.

   The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the *Societies Act* because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

2. In British Columbia, regional health authorities are responsible for the delivery of a wide range of health care services including hospital acute care, residential care, home and community care, community mental health care, and public health services, but excluding physican, laboratory and pharmacare services. Financial reporting does not separate expenditures for services provided under the *Canada Health Act*.

   BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $4.59 billion in 1999–2000, $5.20 billion in 2000–2001, $5.62 billion in 2001–2002, $6.06 billion in 2002–2003, $6.21 billion in 2003–04, $6.25 billion in 2004–2005, $6.62 billion in 2005–2006, and $7.1 billion in 2006–2007.

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	7,618	7,294	7,467	6,517	7,172
7. Total payments, in-patient ($).	40,195,515	45,318,174	51,869,175	49,899,859	65,678,542
8. Total number of claims, out-patient (#).	83,152	81,911	80,386	77,537	81,878
9. Total payments, out-patient ($).	11,223,254	11,105,322	13,574,737	14,089,042	17,937,647
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	1,795	1,970	2,294	2,345	1,858
11. Total payments, in-patient ($).	2,294,341	2,365,051	3,811,717	4,248,649	3,452,739
12. Total number of claims, out-patient (#).	949	611	761	1,247	960
13. Total payments, out-patient ($).	543,969	294,712	741,617	770,215	453,698

Insured Physician Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	4,471	4,573	4,629	4,681	4,756
b. specialists	3,421	3,510	3,642	3,773	3,870
c. other	0	0	0	0	0
d. total	7,892	8,083	8,271	8,454	8,626
15. Number of opted-out physicians (#):					
a. general practitioners	3	3	4	4	3
b. specialists	3	2	2	2	2
c. other	0	0	0	0	0
d. total	6	5	6	6	5
16. Number of not participating physicians (#):					
a. general practitioners	1	1	1	1	1
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	1	1	1	1	1
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	not available	not available	not available	not available	not available
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	61,640,648	63,758,925	65,944,973	70,083,943	72,660,315
b. total payments ($)	1,904,028,933 [3]	1,967,031,496 [3]	1,956,374,356 [3]	2,032,537,376 [3]	2,061,333,925 [3]

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[3] The MSP Fee-for-Service Payments listed in 18b exclude retroactive rate increases to be applied to the 2006/2007 medical expenditure; the amount is yet to be determined.

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
19. Number of services (#).	617,834	604,748	628,099	674,497	673,886
20. Total payments ($).	22,403,444	22,516,419	23,624,476	25,781,441	26,928,627
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	48,457	52,673	65,134	69,741	55,527
22. Total payments ($).	2,145,121	2,281,820	2,767,854	3,121,999	2,551,760

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
23. Number of participating dentists (#).	249	243	228	238	234
24. Number of services provided (#).	36,680	36,809	38,310	41,965	44,015
25. Total payments ($).	5,379,450	5,170,348	5,268,900	5,833,105	6,087,395

Yukon

Introduction

The health care insurance plans operated by the Government of Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director, Insured Health and Hearing Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. There are no regional health boards in the Territory.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services according to the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory on uniform terms and conditions. The Minister, Department of Health and Social Services, is responsible for delivering all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 32,936 eligible persons registered with the Yukon health care plan on March 31, 2007.

Other insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program; the Chronic Disease and Disability Benefits Program; the Pharmacare and Extended Benefits Programs; and the Children's Drug and Optical Program. Non-insured health service programs include Continuing Care; Community Nursing; Community Health; and Mental Health Services.

Health care initiatives in the Territory target areas such as access and availability of services, recruitment and retention of health care professionals, primary health care, systems development and alternative payment and service delivery systems. Specifically:

- Primary care initiatives are proceeding that will broaden and strengthen service delivery, modernize and improve system capabilities. These initiatives include:
  - Insured Health Information System—a new system has been in use for just over a year for the processing of Health Care Registration, Medical Claims, Hospital Claims and Drug Claims. The design stage is underway for the Medical Travel Claims component;
  - work with the Yukon Medical Association to find solutions for a number of Yukon residents without a family physician continues;
  - the establishment of a pace maker clinic in February 2007 that services approximately 60 Yukon residents—as a result residents with pacemakers no longer have to leave the territory for medical check-ups on their pacemaker;
  - planning is underway to recruit a broader base of visiting specialists to provide services at the Visiting Specialist Clinic; and
  - the Diabetes Collaborative, which helps physicians provide improved care for patients with diabetes is operational and entering phase two. This second phase sees physicians in rural areas utilizing the Chronic Disease Management Toolkit from BC to help manage their diabetic cases.

The 2006–2007 health care expenditures increased over the 2005–2006 expenditures as follows:

- Insured Health Services increased by $ 8,500,000;[1]
- Yukon Hospital Services increased by $2,102,272;
- Continuing Care increased by $744,000;
- Community Nursing and Emergency Medical Services increased by $544,302; and
- Community Health Programs increased by $443,265.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

- effective linkages and coordination of existing services and service providers;
- recruitment and retention of qualified health care professionals;
- increasing costs related to service delivery;
- increasing costs related to changing demographics; and
- acquiring and maintaining new and advanced high-technology diagnostic and treatment equipment.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, sections 3(2) and 4, establishes the public authority to operate the health medical care plan. There were no amendments made to these sections of the legislation in 2006–2007.

The *Hospital Insurance Services Act*, sections 3(1) and 5, establishes the public authority to operate the health hospital care plan. There were no amendments made to these sections of the legislation in 2006–2007.

Subject to the *Health Care Insurance Plan Act* (section 5) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in operating the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of Yukon's right of subrogation under this Act to the rights of insured persons;
- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the hospital insurance plan;

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1. Increases are due to additional physicians, increases to benefits for Medical Travel program, rise in reciprocal inpatient and out patient rates and an increase in visiting specialists

- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research programs and obtain statistics for such purposes;
- appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
- prescribe the forms and records necessary to carry out the provisions of this Act; and
- perform such other functions and discharge such other duties as may be assigned by the regulations.

1.2 Reporting Relationship

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services, make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the Legislature and is subject to discussion at that level.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the auditor of the Government of Yukon in accordance with section 30 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

The most recent audit was for the year ended March 31, 2007.

Regarding the Yukon Hospital Corporation, section 11(2) of the *Hospital Act* requires every hospital to submit a report of the operations of the Corporation for that fiscal year; the report is to include the financial statements of the Corporation and the auditor's report. The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

1.4 Designated Agency

The Yukon Health Care Insurance Plan has no other designated agencies authorized to receive monies or to issue payments pursuant to the *Health Care Insurance Plan Act* or the *Hospital Insurance Services Act.*

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9, establish authority to provide insured hospital services to insured residents. The Yukon Hospital Insurance Services Ordinance was first passed in 1960 and came into effect April 9, 1960. There were no amendments made to these sections of the legislation in 2006–2007.

In 2006–2007, insured in-patient and out-patient hospital services were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one hospital and 13 Health Centres.

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the Legislature and the Government to ensure "compliance with appropriate methods of operation and standards of facilities and care". Adopted on November 11, 1994, the Hospital Standards Regulation sets out the conditions under which all hospitals in the Territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establishes and maintains a quality assurance program. Currently, the Yukon Hospital Corporation is operated under a three-year accreditation through the Canadian Council on Health Services Accreditation.

The Yukon government assumed responsibility for operating Health Centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/ Nursing Station Facility/Health Centre Treatment Facility, and the Community Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the Hospital Insurance Services Regulations, sections 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to in-patients, namely: accommodation and meals at the standard or public ward level; necessary nursing service; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability; drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; use of radiotherapy facilities where available; use of physiotherapy facilities where available; and services rendered by persons who receive remuneration therefore from the hospital.

Section 2(f) of the same Regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely: necessary nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury; drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; services rendered by persons who receive remuneration therefore from the hospital; use of radiotherapy facilities where available; and use of physiotherapy facilities where available.

Pursuant to the Hospital Insurance Services Regulations, all in- and out-patient services provided in an approved hospital by hospital employees are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

In 2006–2007, a total of $550,000 was dedicated to the purchase of new hospital equipment, which included implementation of a bar coding/scanning project, the purchase of and Olympus P3 or 4 nasopharengscope, Xomed microdebrider and upgrade to the ENT microscope for the Specialist Clinic.

Additional funding was provided to increase the number of knee replacements performed in Yukon.

An additional $45,000 was dedicated to the establishment of a Satellite Specialist Clinic in Whitehorse.

These measures will help reduce the Territory's reliance on out-of-territory services.

2.2 Insured Physician Services

Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7, 10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to these sections of the legislation in 2006–2007.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are to:

- register for licensure pursuant to the *Medical Professions Act*; and
- maintain licensure, pursuant to the *Medical Professions Act*.

The estimated number of resident physicians participating in the Yukon Health Care Insurance Plan in 2006–2007 was 66.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations allows physicians in the Territory to bill patients directly for insured services by giving notice in writing of this election. In 2006–2007, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations. Services not covered by the Plan include advice by telephone; medical-legal services; preparation of records and reports; services required by a third party; cosmetic services; and services determined to be not medically required.

The process used to add a new fee to the Payment Schedule for Yukon is administered through a committee structure. This process requires physicians to submit requests in writing to the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee.

Following review by this committee, a decision is made to include or exclude the service. The relevant costs or fees are normally set in accordance with similar costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Public consultation is not required.

Alternatively, new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services. The Director, Insured Health and Hearing Services, manages this process and no public consultation is required.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the Territory must be licensed pursuant to the *Dental Professions Act* and are given billing numbers to bill the Yukon Health Care Insurance Plan for providing insured dental services. In 2006–2007, two dentists billed the Plan for insured dental services that were provided to Yukon residents. The Plan is also billed directly for services provided outside the territory.

Dentists are able to opt out of the health care plan in the same manner as physicians. In 2006–2007, no dentists provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Regulations and require the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia).

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the Regulations Respecting Health Care Insurance Services. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services, administers this process.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured.

Uninsured physician services include: services that are not medically necessary; charges for long-distance telephone calls; preparing or providing a drug; advice by telephone at the request of the insured person; medicolegal services including examinations and reports; cosmetic services; acupuncture; and experimental procedures.

Section 3 of the Yukon Health Care Insurance Plan Regulations contains a non-exhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include: non-resident hospital stays; special/private nurses requested by the patient or family; additional charges for preferred accommodation unless prescribed by a physician; crutches and other such appliances; nursing home charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services include: procedures considered restorative; and procedures that are not performed in a hospital under general anaesthesia.

Further, the Act states that any service that a person is eligible for, and entitled to, under any other Act is not insured.

All Yukon residents have equal access to services. Third parties, such as private insurers or the Worker's Compensation Health and Safety Board, do not receive priority access to services through additional payment.

The purchase of non-insured services, such as fibreglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

The Territory has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services, to monitor usage and service concerns.

Physicians in the Territory may bill patients directly for non-insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include, but are not limited to, completion of employment forms; medical-legal reports; transferring records; third party examinations; some elective services; and telephone prescriptions, advice or counselling. Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows:

- **Physician services** — the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Payment Schedule for Yukon, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing. The Director, Insured Health and Hearing Services, manages this process. No services were removed from the Payment Schedule for Yukon in fiscal year 2006–2007.
- **Hospital services** — an amendment by Order-In-Council to section 2 (e) (f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2006, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been deinsured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- **Surgical-dental services** — an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required. A service could be de-insured if determined not medically necessary or is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services, manages this process.

3.0 Universality

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act* and Regulations, sections 2 and 4 respectively, and the *Hospital Insurance Services Act* and Regulations, sections 2 and 4 respectively. Subject to the provisions of these Acts and Regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon. Where applicable, the eligibility of all persons is administered in accordance with the Inter-Provincial Agreement on Eligibility and Portability.

Under section 4(1) of both Regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

Changes affecting eligibility made to the legislation in 2004–2005 now require that all persons returning to or establishing residency in Yukon complete the waiting period. The only exception is for children adopted by insured persons.

The following persons are not eligible for coverage in the Yukon:

- persons entitled to coverage from their home province or territory (e.g., students and workers covered under temporary absence provisions);
- visitors to the Territory;
- refugee claimants;
- members of the Canadian Forces;
- convention refugees;
- members of the Royal Canadian Mounted Police (RCMP);

- inmates in federal penitentiaries;
- study permit holders, unless they are a child and they are listed as the dependent of a person who holds a one year work permit; and
- employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

- establish residency in the Territory;
- become a permanent resident; and
- the day following discharge or release if stationed in or resident in the Territory.

3.2 Registration Requirements

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the Regulations from so doing, shall register himself and his dependants with the Director, Insured Health and Hearing Services, at the place and in the manner and form and at the times prescribed by the Regulations". Registration is administered in accordance with the Inter-Provincial Agreement on Eligibility and Portability.

Persons and dependants under the age of 19 who move permanently to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form available from the Insured Health and Hearing Services office or community Territorial Agents. Once coverage becomes effective, a health care card is issued.

Family members receive separate health care cards and numbers. Health care cards expire every year on the resident's birthday and an updated label with the new expiry date is mailed out accordingly.

As of March 31, 2007, there were 32,936 residents registered with the Yukon Health Care Insurance Plan. There were no residents who notified Insured Health Services of their decision to opt out of the Yukon Health Care Insurance Plan in 2006–2007.

3.3 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals, as follows:

- **Returning Canadians** — waiting period is applied
- **Permanent Residents** — waiting period is applied
- **Minister's Permit** — waiting period is applied, if authorized
- **Foreign Workers** — waiting period is applied, if holding Employment Authorization
- **Clergy** — waiting period is applied, if holding Employment Authorization

Employment Authorizations must be in excess of 12 months.

The estimated number of new individuals receiving coverage in 2006–2007 under the following conditions is:

- **Returning Canadians** — 37
- **Permanent Residents** — 34
- **Minister's Permit** — 0
- **Convention Refugees** — 0
- **Armed Forces** — 3
- **RCMP** — 1

The estimated number of individuals receiving coverage in 2006–2007 under the following conditions is:

- **Foreign Workers** — 35
- **Clergy** — 0

3.4 Premiums

The payment of premiums by Yukon residents was eliminated on April 1, 1987.

4.0 Portability

4.1 Minimum Waiting Period

Pursuant to section 4(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory". All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted from outside Canada by insured persons. (See section 3.1.)

4.2 Coverage During Temporary Absences in Canada

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence". Persons leaving the Territory for a period exceeding three months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in cancellation of the coverage.

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services, may approve other absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director, Insured Health and Hearing Services, may approve absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-Provincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures.

No amendments were made to these sections of the legislation in 2006–2007.

The Yukon participates fully with the Inter-Provincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories with the exception of Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and submit claims to the Yukon Health Care Insurance Plan for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside the Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside the Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 2006–2007:

- **In-patient services** — $8,808,130
- **Out-patient services** — $2,168,964

These figures are by date of service and may be subject to adjustment.

In 2006–2007 payments to out-of-territory physicians totalled $2,139,805.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations. No amendments were made to these sections of the legislation in 2006–2007. Sections 5 and 6 state that "Where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence".

Persons leaving the Territory for a period exceeding three months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in cancellation of the coverage.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada. (See section 4.2.)

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in the Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. The standard ward rate for the Whitehorse General Hospital as of April 1, 2006 was $1,382. This rate is established through Order-in-Council and is derived as follows:

- Standard Ward Rate = (total operating expenses – non-related in-patient costs- related newborn costs – associated out-patient costs) / (total patient days – patient days for other services; e.g., non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $169 and is established through Order-in-Council and derived by the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC).

The following amounts were paid in 2006–2007 for elective and emergency services provided to eligible Yukon residents outside Canada:

- **In-patient services** — $20,257
- **Out-patient services** — $7,101

These figures are by date of service and may be subject to adjustment.

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program or the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Pursuant to the *Hospital Act*, the "Legislature and Government have responsibility to ensure the availability of necessary hospital facilities and programs". The Minister must approve any significant changes to the level of service delivery. Acute care beds are readily available and no waitlist for admission exists at either of Yukon's two acute care facilities.

The estimated number of fulltime equivalent (FTEs) nurses and other health care professionals working in facilities providing insured hospital services in the Yukon as of March 31, 2007, is:

Profession	Whitehorse General Hospital	Watson Lake Cottage Hospital
	# of FTEs	# of FTEs
Registered Nurses	74.75	7.50
Licensed Practical	8.00	0
Nurse Practitioner	0	0
Social Worker	1.00	0
Pharmacist	2.27	0
Physiotherapist	4.55	9.00
Occupational Therapist	1.40	0
Psychologist	0	0
Medical Lab/X-Ray	28.79	0
Dietician	4.50	0
Public Health	0	2.00
Home Care	0	1.00

The Whitehorse General Hospital and Community Nursing manage the supply of nurses and health care professionals in the Territory's two hospitals with the Department of Health and Social Services. Shortfalls in staffing are covered by temporary, casual or auxiliary workers to ensure residents have continued access to insured services.

Recruitment and Retention

Recruitment and retention initiatives include:

Community Nursing

A Yukon Advisory Committee on Nursing was struck to advise the Department of Health and Social Services on nursing issues. Recommendations will help Yukon recruit and retain nurses in both the long and short term. Yukon is providing:

- competitive salaries;
- recruitment and retention bonuses;
- participation at job fairs;
  - training and educational opportunities;
  - travel bonus / $2,000 after one year; and
  - relief positions.

Whitehorse General Hospital

- competitive salaries;
- wage scale recognizes experience;
- cooperative work schedules;
- on-site fitness centre/24-hour;
- monthly clinical skill development;
- continuing education/development; and
- travel bonus / $2,000 after one year.

Facilities

Whitehorse General Hospital

As the only major acute care hospital facility in the Territory, this facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide Emergency Department services on rotation.

Emergency surgery patients at the Whitehorse General Hospital are normally seen within 24 hours. Elective surgery patients are normally seen within one to two weeks. The number of Visiting Specialist clinics is routinely adjusted to address wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3).

Surgical services provided include:

- minor orthopaedics;
- selected major orthopaedics;
- gynecology/obstetrical;
- paediatrics;
- general abdominal;
- mastectomy;
- emergency trauma;
- ear/nose/throat/otolaryngology; and
- ophthalmology including cataracts.

Diagnostic services include:

- radiology (including ultrasound, computed tomography, x-ray and mammography);
- laboratory;
- electrocardiogram; and
- cardiac stress testing.

Selected rehabilitative services are available through out-patient therapies.

Watson Lake Hospital

This primary acute care facility is located in Watson Lake. Medical services include emergency trauma, low-risk maternity, medicine, paediatrics, palliative and respite care. Diagnostic services include x-ray, laboratory and electrocardiogram. This is a 12-bed facility and there is no waitlist for admission.

Health Centres

Out-patient and 24-hour emergency services are provided at the remaining 13 community Health Centres by Community Nurse Practitioners and auxiliary nursing staff.

Patients requiring insured hospital services not available locally are transferred to acute care facilities in territory or out-of-territory through the Travel for Medical Treatment Program.

Measures to Improve Access

A number of measures have been taken to better manage access to insured hospital services. The Department of Health and Social Services continues to work with the Yukon Hospital Corporation and Community Nursing to ensure the current waiting time for insured hospital services in the Territory is reduced or maintained at existing levels. For example:

- Heart defibrillators were made available in all rural Yukon Health Centres. This provides an important tool for Community Nurse Practitioners and improves local access to cardiac care.
- Officials from the Department attend nursing recruitment fairs across Canada and provide information on working in the Territory to nurses in attendance.
- The Technical Review Committee continues to make recommendations to the Department on health programs and services in the Yukon as required. Its mandate is to develop criteria for initiating, eliminating, expanding or reducing programs or services.
- Telehealth provides real-time video in all Yukon communities, giving outlying rural communities access to Whitehorse. As well, Whitehorse and the rural communities can access services from outside centres in British Columbia or Alberta.
- Telehealth educational sessions continue to occur regularly between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia. These sessions are attended by patients, physicians, nurses, social workers, psychiatrists, mental health counsellors and allied professionals such as Community Health Representatives and First Nation Wellness workers.

5.3 Access to Insured Physician and Surgical-Dental Services

Existing legislation and administration of services provides all eligible Yukon residents with equal access to insured physician and dental services on uniform terms and conditions.

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2007, (see Statistical Table item #14):

- **General/Family Practitioners** — 57
- **Specialists** — 9
- **Dentists** — 2

Beyond the usual distribution of physicians and specialists in the Territory, uniform access to insured physician and dental services is ensured through the Travel for Medical Treatment Program. This program covers the cost of medically necessary transportation, allowing eligible persons to access services that are not available in their home communities. Eligible persons are routinely sent to Whitehorse, Vancouver, Edmonton or Calgary to receive services.

Most physicians in the Yukon are located in Whitehorse. Beyond Whitehorse, only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. One contracted physician provides resident services in Mayo.

The Visiting Physician Program provides local access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians providing visiting services through this program are compensated under contract for travel time, mileage, meals and accommodation, in addition to a sessional rate or fee-for-service billings.

In addition, the Department of Health and Social Services and the Visiting Specialist Program provide local access at the Whitehorse General Hospital, Mental Health Services or the Yukon Communicable Disease Unit to non-resident visiting specialist services not regularly available in the Territory. Visiting specialists are reimbursed for expenses in addition to a sessional rate or fee-for-service billings.

The number of specialists providing services under the Visiting Specialist Program and the Department of Health and Social Services is:

- **Ophthalmology** — 2
- **Oncology** — 3
- **Internal Medicine** — 2
- **Otolaryngology** — 1
- **Neurology** — 2
- **Rheumatology** — 1
- **Dermatology** — 1
- **Dental Surgery** — 3
- **Infectious Disease** — 1
- **Psychiatry** — 3
- **Orthopaedics** — 4
- **Cardiology** — 3

Visiting Specialist clinics at Whitehorse General Hospital are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2007, the waitlist for non-emergency specialist services was estimated at:

- **Ophthalmology** — 12 to 18 months
- **Orthopaedics** — 2 to 24 months
- **Otolaryngology** — 1 to 3 months
- **Rheumatology** — 3 to 5 months
- **Dental Surgery** — 2 to 6 months

Visiting Specialist Clinics at the Satellite clinic are held between one and twelve times per year depending on demand and availability of specialists. As of March 31, 2007, the waitlist for non-emergency specialist services was estimated at:

- **Neurology** — 1 to 4 months
- **Gastroenterology** — 1 to 6 months
- **Internal Medicine** — 1 to 2 months

Dental surgery services are not provided through the Visiting Specialist as administered by the Whitehorse General Hospital. There are no waitlists for visiting services not included in the above listing. Patients are seen on the next scheduled visit.

The Department of Health and Social Services has taken several measures to reduce waiting times for insured physician services. A variety of recruitment and retention initiatives were begun in 2001–2002 and 2002–2003 such as a Resident Support Program; Locum Support Program; Physician Relocation Program; Education Support; and a Rural Training Fund. The Department of Health and Social Services continues to work with the Yukon Medical Association to find additional cooperative initiatives to be implemented within the terms of the renewed Memorandum of Understanding in April 1, 2004.

Other measures taken in 2006–2007 to ensure access and reduce wait times:

> Yukon has declared a need that will permit internationally trained medical graduates to be granted a special license to practice in Yukon. These physicians will work under the supervision of a resident Yukon physician and provide medical services to the residents of Whitehorse.

The Yukon Government developed a Human Resource Strategy in 2006 of which a key component is the implementation of the Family Physician Incentive Program for New Graduates. This program provides newly graduated family physicians who meet the eligibility requirements with financial assistance in exchange for years of service in the Yukon. Also under the strategy, Yukon established a bursary to support students in both medical and health profession post-secondary institutions.

Physicians have indicated that they are interested in exploring new models for health care provision. The Government is working with physicians in Yukon to facilitate this.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, before entering negotiations with the Yukon Medical Association (YMA). The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent four-year Memorandum of Understanding came into effect April 1, 2004, and shall remain in effect to March 31, 2008. This MOU establishes the terms and conditions for payment of physicians and established two new programs: New Patient Program, and Physician Retention Program.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations. No amendments were made to these sections of the legislation in 2006–2007.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2006–2007, one full-time resident rural physician and four resident specialists were compensated on a contractual basis. One physician providing visiting clinics in an outlying community was paid a sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital) through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated and adjusted based on operational requirements and utilization projections from prior years. In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The Watson Lake Cottage Hospital and all Health Centres are funded through the Yukon government's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Regulations. The legislation and Regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons. No amendments were made to these sections of the legislation in 2006–2007.

6.0 Recognition Given to Federal Transfers

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2006–2007 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1) (d) (e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act* acknowledge the contribution of the Government of Canada.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care

Continuing Care Health Services are available to eligible Yukon residents. In 2006–2007, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services:

- personal care;
- extended care services;
- intermediate care;
- special care;
- complex care;
- respite care;
- day program; and
- meals on wheels.

In total, there were 138 continuing care beds in the Territory in 2006–2007.

Home Care Services

The Yukon Home Care Program provides assessment and treatment, care management, personal support, homemaking services, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. Some rural communities have a dedicated home care nurse, though many rural communities provide nursing services through the community nursing program. Home support workers assist clients with personal care, homemaking and respite services. Therapy services are provided by a travelling regional team of physiotherapists and occupational therapists. Services are available Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided. Twenty-four hour care is not available.

There is no legislated requirement for home care services in Yukon.

No other major changes were made in the administration of these services in 2006–2007.

7.3 Ambulatory Health Care Services

The Yukon Home Care Program provides the majority of ambulatory health care services outside institutional settings. Most other services are provided through Community Nursing or Public Health. All residents have equal access to services.

These services are not provided for in legislation. There were some changes made in the administration of these services in 2005–2006. The Travel for Medical Treatment Program has increased both the subsidy amount and the mileage reimbursement amounts. Eligible individuals are now able to collect $75/day starting on the second day they are on Medical Travel Status. Mileage reimbursement for those who travel by automobile has been increased to $.30/km. In addition to the services described above, the following are also available to eligible Yukon residents outside the requirements of the *Canada Health Act*:

- The Chronic Disease and Disability Benefits Program provides benefits for eligible Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medical surgical supplies and equipment. (Chronic Disease and Disability Benefits Regulation)
- The Pharmacare Program and Extended Benefits programs are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services and medical surgical supplies and equipment. (Pharmacare Plan Regulation and Extended Health Care Plan Regulation)
- The Travel for Medical Treatment Program assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation to receive services not available locally. (*Travel for Medical Treatment Act* and Travel for Medical Treatment Regulation)
- The Children's Drug and Optical Program is designed to assist eligible low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 and younger. (Children's Drug and Optical Program Regulation)
- Mental Health Services provide assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. (*Mental Health Act* and Mental Health Act Regulations)
- Public Health is designed to promote health and well-being throughout the Territory through a variety of preventive and education programs. This is a non-legislated program.
- Emergency Medical Services is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non-legislated program.
- Hearing Services provides services designed to help people of all ages with a variety of hearing disorders, by providing routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.
- Dental Services provides a comprehensive diagnostic, preventive and restorative dental service to children from preschool to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for preschool to grade 12. This is a non-legislated program.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	30,534	30,917	31,505	32,226	32,936

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
2. Number (#):					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other [2]	13	13	13	13	13
e. total	15	15	15	15	15
3. Payments for insured health services ($): [3]					
a. acute care	22,515,448	24,877,479	26,255,596	29,150,174 [4]	33,739,214
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other [2]	6,133,453	6,318,565	6,509,897	6,862,368	7,718,344
e. total	28,648,901	31,196,044	32,765,493	33,729,869 [4]	41,457,558
Private For-Profit Facilities	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	666	783	674	714	738
7. Total payments, in-patient ($).	5,861,530	7,587,906	5,857,725	8,698,387	8,808,130
8. Total number of claims, out-patient (#).	7,241	6,938	7,412	8,450	8,735
9. Total payments, out-patient ($).	1,037,692	936,376	1,306,531	1,735,520	2,168,964
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	9	8	14	15	11
11. Total payments, in-patient ($).	9,339	13,536	30,566	43,454	20,257
12. Total number of claims, out-patient (#).	26	46	64	55	42
13. Total payments, out-patient ($).	2,451	5,994	9,965	8,372	7,101

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2. Includes 13 health centres.

3. Amounts include payments for operating and maintenance and capital.

4. Figure adjusted as Watson Lake Hospital inadvertently excluded in the 2005/06 submission.

Insured Physician Services Within Own Province or Territory [5]

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#): [6]					
a. general practitioners	53	55	54	55	57
b. specialists	6	8	8	9	9
c. other	0	0	0	0	0
d. total	59	63	62	64	66
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	232,624	235,642	238,797	248,646	254,170
b. total payments ($)	10,625,211	11,769,018	12,892,522	13,752,251	13,788,028
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	197,519	200,462	219,031	225,815	245,069
b. total payments ($)	7,711,835	8,321,114	9,201,579	9,847,991	11,076,701
Visiting Specialists, Locum Doctors and Member Reimbursements: [7]					
a. number of services (#)	34,726	27,274	13,035	17,127	32,272
b. total payments ($)	1,980,657	1,840,478	1,495,701	1,886,289	2,323,060

Insured Physician Services Provided to Residents in Another Province or Territory

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	34,853	34,037	35,401	35,781	39,669
20. Total payments ($).	1,799,019	1,833,654	1,921,260	1,873,508	2,139,805
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	not available	not available	not available	not available	not available
22. Total payments ($).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory [8]

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	8	6	6	6	2
24. Number of services provided (#).	150	104	30	24	not available [9]
25. Total payments ($).	37,342	25,093	29,712	25,072	not available [9]

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5. Includes on-call payments to physicians.
6. Includes only resident family physicians and specialists.
7. Includes Visiting Specialists, Member Reimbursements, Locum Doctors, and Optometrist testing paid through fee-for-service. Excludes services and costs provided by alternative payment agreements.
8. Includes direct billings for insured surgical-dental services received outside the territory.
9. Implementation of new information system occurred in 06/07. There have been some data conversion issues that are being resolved. Dental information will be reported again next year.

Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, (henceforth the Department) together with seven Health and Social Services Authorities (HSSAs) and the Tlicho Community Services Agency (TCSA), plan, manage, and deliver a wide spectrum of community and facility-based services for health care and social services. Community health programs include drop-in clinics, public health clinics, home care, school health programs, and educational programs. Physicians and some specialists routinely visit communities without resident physicians. Services also include early intervention and support to families and children, mental health, and addictions.

As of April 1, 2007, there were more than 40,000 people living in the Northwest Territories, of which half were Aboriginal. The NWT continues to have a relatively young population and a high birth rate. According to 2006 population estimates, approximately 25 percent of the NWT population is under 15 years of age, compared with 17 percent in the overall Canadian population.[1]

During the reporting period, the Department undertook several important initiatives, including:

- The implementation of the *Tobacco Control Act*. This Act prohibits smoking in all public places and controls the sale and display of tobacco in the NWT. Pharmacies, recreation facilities, and vending machines no longer sell tobacco products. Retailers are not permitted to display tobacco products, and are required to exhibit signs disclosing tobacco-related health risks.
- The passing of the new *Pharmacy Act* in November of 2006. This Act reflects a number of differences from the previous *Pharmacy Act*, ensuring that the public receives quality pharmaceutical service and care. The new Act recognizes health care professionals and the National Association of Pharmaceutical Regulatory Authorities' drug schedules, permits pharmacists to accept faxed prescriptions, and allows for discipline provisions such as an alternative dispute resolution process.

The Department maintains a bilingual (English and French) public website (www.hlthss.gov.nt.ca) that provides an exhaustive source of information, including electronic copies of reports published by the Department.

1.0 Public Administration

1.1 Health Care Insurance Plans and Public Authority

The NWT Health Care Plan includes the Medical Care Plan and the Hospital Insurance Plan. The public authority responsible for administering the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through Boards of Management established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA).

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[1] Statistics Canada.

Legislation that enables the Health Care Insurance Plan in the NWT includes the *Medical Care Act* and *Hospital Insurance and Health and Social Services Administration Act*.

1.2 Reporting Relationship

The Department, together with seven Health and Social Services Authorities (HSSAs) and the Tlicho Community Services Agency (TCSA), plan, manage, and deliver a wide spectrum of community and facility-based services for health care and social services.

In the NWT, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for administering the *Medical Care Act* and the Regulations and to report to the Minister concerning the operation of the Medical Care Plan.

The Minister also appoints members to a Board of Management for each Heath and Social Services Authority in the NWT. Boards of Management provide NWT residents with the opportunity to shape priorities and service delivery for their communities. The Boards manage, control and operate health and service facilities. The Boards' chairpersons hold office indefinitely, while other members hold office for a term of three years. In the Tlicho, community governments appoint members to the Tlicho Board of Management for a maximum of four years.

An annual audit of accounts is performed on each Board of Management. The Minister has regular meetings with Board of Management chairpersons. This forum allows the chairpersons to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Office of the Auditor General of Canada (OAG) audits the payments made under each plan, as part of the GNWT annual audit.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the authority of the HIHSSA and the Regulations.

During 2006–2007, four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The NWT provides coverage for a full range of insured hospital services. Insured in-patient services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures together with the necessary interpretations; drugs, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and services rendered by an approved detoxification centre.

The NWT also provides a number of out-patient services. These include: laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy and speech therapy services in an approved hospital; and psychiatric and psychology services provided under an approved hospital program.

A detailed list of insured in- and out-patient services is contained in the Hospital Insurance Regulations. Section 1 of the Regulations states that "out-patient insured services" means the following services and supplies are provided to out-patients: laboratory, radiological and other diagnostic procedures together with the necessary interpretations for helping diagnose and treat any injury, illness or disability, but not including simple procedures such as examinations of blood and urine, which ordinarily form part of a physician's routine office examination of a patient; necessary nursing services; drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; services rendered by persons who receive remuneration for those services from a hospital; radiotherapy services within insured facilities; and physiotherapy services within insured facilities.

The Minister may add, change or delete insured hospital services. The Minister also determines if any public consultation will occur before making changes to the list of insured services.

Where medically necessary services are not available in the NWT, residents travel to hospitals or clinics in other jurisdictions. The NWT provides Medical Travel Assistance (as outlined in the Medical Travel Policy), which ensures that NWT residents have no barriers to accessing medically necessary services. The Department also administers several supplementary health benefits programs.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide for insured physician services.

Physicians, nurses, nurse practitioners, and midwives are allowed to provide insured services under the health care insurance plan. Physicians and nurse practitioners must be licensed to practice in the NWT. Midwifes and nurses must meet registration requirements set out respectively in the *Midwifery Profession Act* and the *Nursing Profession Act*. As of March 31, 2007, there were 253 licenses issued, most to locums.

A physician may opt-out and collect her or his fees otherwise than under the Medical Care Plan, by delivering to the Director of Medical Insurance a written notice to that effect. There are no physicians who opted-out of the Medical Care plan as of March 2007.

A wide range of medically necessary services is provided in the NWT. No limitation is applied if a service has been deemed an insured service. The Medical Care Plan insures all medically required procedures provided by medical practitioners, including: approved diagnostic and therapeutic services; medically necessary surgical services; complete obstetrical care; eye examinations provided by an Ophthalmologist; and with proper referral from an approved medical practitioner, visits to specialists.

It is the responsibility of the Director of Medical Insurance to prepare and recommend to the Minister a tariff itemizing the benefits payable in respect of insured services. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations, as follows:

- establishing a medical care plan that provides insured services to insured persons by medical practitioners that will in all respects qualify and enable the NWT to receive payments of contributions from the Government of Canada under the *Canada Health Act*; and
- prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the NWT, and the conditions under which the fees and charges are payable.

2.3 Insured Surgical-Dental Services

Insured services and those related to oral surgery, injury to the jaw or disease of the mouth/jaw are eligible. Only licensed oral surgeons may submit claims for billing. The NWT uses the Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided by hospitals, physicians and dentists, but not covered by the NWT Health Care Insurance Plan, include: medical-legal services; third-party examinations; services not medically required; group immunization; in vitro fertilization; services provided by a doctor to his or her own family; advice or prescriptions given over the telephone; surgery for cosmetic purposes except where medically required; dental services other than those specifically defined for oral surgery; dressings, drugs, vaccines, biologicals and related materials administered in a physician's office; eyeglasses and special appliances; plaster and surgical appliances or special bandages; treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act* and Regulations; physiotherapy and psychology services received from other than an insured out-patient facility; services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and routine annual checkups where there is no definable diagnosis.

In the NWT, prior approval applications must be made to the Director of Insured Services for uninsured medical goods or services provided in conjunction with an insured health service. A Medical Advisor provides the Director with recommendations regarding the appropriateness of the request.

The *NWT Medical Care Act* includes Medical Care Regulations and provides for the authority to negotiate changes or deletions to tariffs. The process is described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* defines the eligibility of NWT residents for the NWT Health Care Insurance Plan.

The NWT uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the NWT Health Care Plan Registration Guidelines to define eligibility. There were no changes to eligibility for the reporting period.

Ineligible individuals for NWT health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP), federal inmates and residents who have not completed the minimum waiting period. For persons discharged from the Canadian Armed Forces, RCMP, federal penitentiary, or Canadian citizens returning to the NWT from living outside Canada, coverage is effective the day permanent residency is established.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable; e.g., visas and immigration papers. The applicant must be prepared to provide proof of residency if requested. Registration should occur before the actual eligibility date of the client. NWT health care cards are valid for a five-year period. Registration and eligibility for coverage are directly linked. Only claims from registered clients are paid.

As of March 2007, there were 45,551 individuals registered with the NWT Health Care Plan.

No formal provisions are in place for clients to opt out of the Health Care Insurance Plan.

3.3 Other Categories of Individuals

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and Guidelines for health care plan coverage.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the NWT. The waiting periods are consistent with the Interprovincial Agreement on Eligibility and Portability. Generally the waiting periods are the first day of the third month of residency, for those who move permanently to the NWT, or the first day of the thirteenth month for those with temporary employment of less than 12 months, but who can confirm that the employment period has been extended beyond the 12 months.

4.2 Coverage During Temporary Absences in Canada

The Interprovincial Agreement on Eligibility and Portability and the NWT Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the NWT for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the NWT for work, vacation, etc. Once an individual has completed a Temporary Absence form and been approved by the Department as being temporarily absent from the NWT, the full cost of insured services is paid for all services received in other jurisdictions.

When a valid NWT health care card is produced, most doctor visits and hospital care for medically necessary services will be billed directly to the NWT Department of Health and Social Services. General reimbursement guidelines are in place for patients who are required to pay for medically necessary services up front. During the 2006–2007 fiscal year, over $14 million was paid for in- and out-patient hospital services received in other provinces and territories.

The NWT participates in both the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The NWT Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada.

As per subsection 11 (1) (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. The NWT does provide personal reimbursement when an NWT resident leaves Canada for a temporary period for personal reasons such as vacations and requires medical attention during that time. Individuals are required to cover their own costs and seek reimbursement upon their return to the NWT. Benefits payable are provided in the approved tariff. If services are rendered outside Canada, the benefits payable must not exceed the benefits for insured services rendered in the Territories.

Individuals may be granted coverage for up to a year with prior approval, if they are outside the country. In the eligibility rules, NWT residents may continue their coverage for up to one year if they are leaving Canada, but they must provide extensive information confirming that they are maintaining their permanent residence in the NWT.

4.4 Prior Approval Requirement

The NWT requires prior approval if coverage is to be considered for elective services in other provinces, territories and outside the country. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Program ensures that economic barriers are reduced for all NWT residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed unless the medical practitioner has made an election to collect her or his fees for medical services to insured persons otherwise than under the Medical Care Plan.

5.2 Access to Insured Hospital Services

Facilities in the NWT offer a range of medical, surgical, rehabilitative, and diagnostic services. The NWT Medical Travel Program ensures that residents will have access to necessary services not available in NWT facilities. Through the use of medical travel arrangements, access to services was maintained throughout the year.

During 2006–2007, Telehealth services were expanded to include a total of 17 units across the NWT. The Department has completed a three-year strategic plan, and is currently developing project proposals based on this plan. One such proposal is in regards to the provision of Speech Language Pathology to school age children in each community.

With regards to recruiting and retaining professional staff, the NWT faces the same challenges as the rest of Canada. In addition, the NWT faces unique demands due to its remoteness and socio-economic realities.

The Department developed a comprehensive five-year human resource strategy in 2004 to address these issues. This strategy outlined alternatives available to the NWT Health and Social Service System to increase the supply of health professionals required to meet the health care needs of NWT residents. Initiatives directly related to increasing the supply of health professionals include: the promotion of health careers, succession planning, and maximizing northern employment.

In the effort to maximize the effectiveness of recruitment, the GNWT established a Health Recruitment Unit in 2006. This Unit is dedicated to the recruitment of public service allied health care professionals and results in several advantages, including the ability to react to changes in healthcare personnel needs throughout the NWT.

5.3 Access to Insured Physician and Surgical-Dental Services

All NWT residents have access to all facilities operated by the Government of the Northwest Territories.

Through the Medical Travel Program, the GNWT ensures that residents have access to physicians, while the Telehealth program expands the specialist services available to residents in isolated communities.

5.4 Physician Compensation

Physician compensation is determined through negotiations between the NWT Medical Association and the Department. The majority of family physicians are employed through a contractual arrangement with the GNWT. The remainder provide services through a fee-for-service arrangement. The *Medical Care Act* and Regulations are used in the NWT to govern amounts to be paid to physicians where insured services are provided on a fee-for-service basis.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department. Amounts allocated in the agreements are based on the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the HIHSSA and the *Financial Administration Act.* No amendments were implemented in 2006–2007 to provisions involving payments to facilities. A comprehensive budget is used to fund hospitals in the NWT.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health Transfer (CHT) has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents.

For fiscal year 2006–2007, these documents included:

- 2006–2007 Budget Address;
- 2006–2007 Main Estimates;
- 2005–2006 Public Accounts; and
- 2005–2008 Business Plan for the Department of Finance.

The Main Estimates (noted above) represent the government's financial plan, and are presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Continuing Care programs and services offered in NWT communities may include: supported living, adult group homes, long-term care facilities, and extended care facilities. These programs and services operate where applicable according to HIHSSA and the Hospital Standards Regulations.

Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home care services. Current services in this area include supported living arrangements in family homes, apartments and group-living homes, where clients live as independently as possible. Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.

The NWT Home Care Program is established to provide community health care services to support independent living, to develop appropriate care options to support continued community living, and to facilitate admission to institutional care when community living is no longer a viable alternative. Home Care is based on need and is available to NWT residents without charge. The range of Home Care services includes: acute care, post-hospital care, chronic illness care, nutrition services, palliative care, personal care, medication management and monitoring, foot care, social support, ambulation, physical/occupational therapy, transportation assistance, equipment loan, and respite care.

Home care services are delivered through the HSSAs and the Tlicho Community Services Agency, and are based on multi-disciplinary assessments of individual needs. The Home Care Program provides services to the seven regions of Yellowknife, Hay River, Fort Smith, Beaufort-Delta, Sahtu, Deh Cho, and Tlicho. There is no specific NWT Home Care legislation. Home care is funded through the Department of Health and Social Services as a core service. The services have been enhanced through funding from the First Nation and Inuit Health Branch.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	40,399 [2]	43,202 [2]	44,504 [2]	44,082 [2]	45,551 [2]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
2. Number (#): a. acute care b. chronic care c. rehabilitative care d. other e. total	 4 not applicable [3] not applicable [3] 28 [4] 32	 4 not applicable [3] not applicable [3] 28 [4] 32	 4 not applicable [3] not applicable [3] 28 [4] 32	 4 not applicable [3] not applicable [3] 28 [4] 32	 4 not applicable [3] not applicable [3] 28 [4] 32
3. Payments for insured health services ($): a. acute care b. chronic care c. rehabilitative care d. other e. total	 not available not applicable [3] not applicable [3] not available 48,384,356	 not available not applicable [3] not applicable [3] not available 51,553,729	 not available not applicable [3] not applicable [3] not available 56,475,975	 not available not applicable [3] not applicable [3] not available 56,228,443	 not available not applicable [3] not applicable [3] not available 62,789,300
Private For-Profit Facilities	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**	**2006–2007**
4. Number of private for-profit facilities providing insured health services (#): a. surgical facilities b. diagnostic imaging facilities c. total	 0 0 0	 0 0 0	 0 0 0	 0 0 0	 0 0 0
5. Payments to private for-profit facilities for insured health services ($): a. surgical facilities b. diagnostic imaging facilities c. total	 not applicable not applicable not applicable	 not applicable not applicable not applicable	 not applicable not applicable not applicable	 not applicable not applicable not applicable	 not applicable not applicable not applicable

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	1,237	1,338	1,246	1,183	1,094 [5]
7. Total payments, in-patient ($).	8,580,504	8,737,798	9,015,697	11,347,098	11,566,331 [5]
8. Total number of claims, out-patient (#).	9,172	9,591	10,252	10,634	12,010 [5]
9. Total payments, out-patient ($).	1,834,134	2,110,818	2,573,103	2,628,794	2,673,172 [5]
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	2	1	2	8	17 [5]
11. Total payments, in-patient ($).	1,258	216	165	13,718	38,967 [5]
12. Total number of claims, out-patient (#).	56	21	19	54	46 [5]
13. Total payments, out-patient ($).	124,725	20,735	4,972	7,280	13,062 [5]

All data are subject to future revisions.

[2] 2001–02 figure is as of September 18, 2002, 2002–03 figure is as of September 2, 2003, the 2003–2004 figure is as of August 25, 2004, 2004–05 figure as of September 1, 2005, 2005–06 figure as of September 6, 2006 and the 2006–07 figure as of September 6, 2007.

[3] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

[4] Includes Health Centres and Public Health Units.

[5] 2006/07 figures are projections based on year to date claim entry.

Insured Physician Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	37 [6]	44 [6]	56 [6]	56 [6]	57 [7]
b. specialists	16 [6]	15 [6]	21 [6]	21 [6]	21 [7]
c. other	155 [7]	169 [7]	139 [7]	155 [7]	175 [8]
d. total	208 [9]	228 [9]	216 [9]	232 [9]	253 [9]
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	195,512	200,866	210,371	186,093	171,314
b. total payments ($)	20,504,000	28,791,514	28,761,951	30,127,892	30,569,939
18. Services provided by physicians paid through fee-for-service:					
a. number of services (#)	24,018	26,326	28,509	28,818	27,976
b. total payments ($)	1,441,954	1,513,440	1,570,686	1,574,842	1,670,071

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	43,571	41,658	43,211	51,079	44,111
20. Total payments ($).	2,790,861	2,973,537	3,124,955	3,981,191	3,408,204
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	135	83	91	85	79
22. Total payments ($).	40	407	20,103	38,722	39,083

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	not available	not available	not available	not available	not available
24. Number of services provided (#).	not available	not available	not available	not available	not available
25. Total payments ($).	not available	not available	not available	not available	not available

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All data are subject to future revisions.

6. 2006/07 figures are projections based on year to date claim entry.

7. 2001/02 numbers from Canadian Institute for Health Information, Southam Medical Database; and 2002/03 and 2003/04 numbers are estimates from NWT Department of Health and Social Services. 2004/05 to 2006/07 figures are based on funded positions.

8. This is an estimate of the number of locum physicians.

9. Estimate based on total active physicians for each fiscal year.

Nunavut

Introduction

On April 1, 1999, Nunavut became Canada's third and newest territory. The Territory spans two million square kilometres and covers one-fifth of Canada's total landmass. There are 25 communities located across three time zones in Nunavut. The Territory is divided into three regions: the Baffin, which consists of 13 communities; the Kivalliq, which consists of seven communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population in Nunavut was 31,113 as of July 1, 2007.

Approximately 53 percent of the population is under the age of 25 years. Inuit make up about 85 percent of Nunavut's population. There is a small French-speaking population of about 4 to 6 percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, which largely includes skilled labourers and seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories (as Nunavut statutes) pursuant to the *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review existing legislation to ensure its relevancy and appropriateness with the Government of Nunavut's objectives as outlined in "Pinasuaqtavut 2004–2009". "Pinasuaqtavut 2004–2009" describes the Government's commitment to building Nunavut's future by achieving healthy communities, simplicity and unity, self-reliance and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimajatuqangit, in program and policy development as well as in service design and delivery, is an expectation placed on all government departments.

The delivery of health services in Nunavut is based on a primary health care model. There are local health centres in 24 communities across Nunavut, including new regional facilities in Rankin Inlet and Cambridge Bay (with in/out patient capacity) and one regional hospital in Iqaluit. The primary health care providers are family physicians, nurse practitioners, community health nurses, and pharmacists. Of concern is the loss of two full time physicians in Nunavut this past year, as both have chosen to leave the Territory. The full-time family physicians number 13 across Nunavut (although there is funding for 18 Full Time Equivalent positions): 10 in the Baffin region; two in the Kivalliq region; and one in the Kitikmeot region. Nunavut recruits and hires its own family physicians and when necessary, accesses specialist services from health centres in Ottawa, Toronto, Winnipeg, Yellowknife and Edmonton. A new website was created in 2006–07 as part of the recruitment and retention initiative, it can be found at:

www.nunavut-physicians.gov.nu.ca

The management and delivery of health services in Nunavut was integrated into the overall operations of the Department on March 31, 2000, when the former regional boards (Baffin, Kitikmeot and Keewatin/Kivalliq) were dissolved. Former board staff became employees of the Department at that time. The Department has a regional office in each of the three regions that manages the delivery of health services at a regional level. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The Territorial budget for health care and social services in 2006–2007 was $277,524,000, which includes approximately $40,264,000 allocated for capital projects. This represents an increase of $36,913,000 from 2005–2006 funding levels.

In 2005–2006, Telehealth was further expanded and made available to all 25 communities in Nunavut. In 2006–2007 it was further realigned, and increased its clinical sessions by 5% from the previous year. Nunavut's Telehealth network provides communities with a broad range of health-related services, which include the following: clinical program delivery such as specialist consultation services; health education; continuing medical education; family visitation; and administrative functions. The network also saw new usage for a wider range of services such as; discharge planning, Tele-psychiatry, Geriatrics, Occupational Therapy, and Patient Post-operation Follow-up. The network was successful in significant financial savings associated with medical travel as in 2005–2006 some 753 trips were avoided as a result of Telehealth consultations.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Despite aggressive national and international recruitment and retention activities, Nunavut continues to be challenged by the acute shortage of nurses. Still, it is important to note that due to focused recruitment initiatives, 34 new additional international nurses were recruited to work in Nunavut during 2005–2006. Presently there are 23 international nurses working throughout the Territory. In 2006–2007 fifteen (15) of the international nurses left the Territory and are working towards full certification through Canadian Registered Nursing Exam (CRNE). Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists are also a challenge.

Over one quarter of the Department's total operational budget is spent on costs associated with medical travel and treatment provided in out-of-territory facilities. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent out of the Territory. In fall 2005, two new regional health facilities, one in Rankin Inlet and one in Cambridge Bay were opened. In addition, a new regional hospital in Iqaluit is scheduled to open in the fall of 2007. These facilities will enable Nunavut to build internal capacity and enhance the range of services that can be provided within the Territory.

With funds from the Primary Health Care Transition Fund, the Government of Nunavut established a new family practice clinic in Iqaluit. The clinic has set a goal being staffed by two family physicians and three nurse practitioners on a community-based health services delivery model. In its first year of operation it was successful in helping to reduce pressure on the emergency and out-patient departments of the Baffin Regional Hospital during working hours. At the present time two nurse practitioners provide a collaborative practice clinic providing primary health care services to the community of Iqaluit with a monthly average of 2 consult visits from doctors of the Baffin Regional Hospital; the clinic averages 200 patients visits per month or 15 to 18 patients per day with 2 nurse practitioners.

Health promotion and prevention activities are high on the Department's list of service priorities. This includes strategies to reduce tobacco use, public education for healthy lifestyle choices, foetal alcohol spectrum disorder (FASD) awareness, diabetes awareness and prevention, the importance of traditional foods, and pre-natal nutrition. Strategies implemented in Nunavut to reduce tobacco use have produced demonstrated results, including a 12 percent drop in smoking among youth in Nunavut since 2004.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) enables the establishment of hospital and other health services.

Through the *Dissolution Act* (Nunavut, 1999), the three former Health and Social Services Boards of Baffin, Kitikmeot and Keewatin/Kivalliq were dissolved and their operations were integrated into the Department of Health and Social Services effective April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

There have been no legislative amendments in fiscal year 2006–2007.

1.2 Reporting Relationship

A Director of Medical Care is appointed under the *Medical Care Act* and is responsible for the administration of the Territory's medical care insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. Our annual submissions to the *Canada Health Act Annual Report* serve as the basis for these reports under the *Medical Care Act*.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The 2005 *Report of the Auditor General of Canada to the Legislative Assembly of Nunavut* was tabled in February, 2005, and can be accessed at:

www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_e.html

There were no references to the operation of the health care insurance plan or to the principles of the *Canada Health Act* in the report. Plans are underway to conduct an audit for the 2006–2007 year.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and Regulations, sections 2 to 4. No amendments were made to the Act or regulations in 2006–2007.

In 2006–2007, insured hospital services were delivered in 25 facilities across Nunavut, including a general hospital located in Iqaluit, two regional health facilities (located in Rankin Inlet and Cambridge Bay), as well as 22 community health centres. The Baffin Regional Hospital in Iqaluit is currently the only acute care facility in Nunavut providing a range of in- and out-patient hospital services as defined by the *Canada Health Act*. However, as the two regional facilities in Rankin Inlet and Cambridge Bay are able to recruit additional physicians, they will also be able to offer a broader range of in-patient and out-patient services offered at community health centres. Community health centres provide public health, out-patient services and urgent treatment centre services. There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre. Public health services are provided at Public Health Clinics in Rankin Inlet and Iqaluit.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services facilities in the Territory.

Insured in-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case-room and anaesthetic facilities; use of radiotherapy and physiotherapy services where available; psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and services rendered by an approved detoxification centre.

Out-patient services include: laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy, limited audiology and speech therapy services in an out-patient facility or in an approved hospital; and psychiatric and psychology services provided under an approved hospital program.

The Department of Health and Social Services makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Nunavut Financial Management Board.

No new services were added in 2006–2007 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1), and Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to the Act or regulations in 2006–2007.

The *Nursing Act* (2004) now allows for licensure of nurse practitioners in Nunavut as a result of legislative amendments; previously only medical doctors were permitted to deliver insured physician services in Nunavut. The Department examined and was successful in introducing legislative amendments that now give nurse practitioners an expended role in the delivery of primary health care in the communities. An amendment to the *Nursing Act* was approved during the February 2007 session of the Legislative Assembly of Nunavut.

Physicians must be in good standing with a College of Physicians and Surgeons (Canada) and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 20 full-time physician positions in Nunavut (11 in the Baffin region; four and half positions in the Kivalliq region; and two and half positions in the Kitikmeot region), as well as one surgeon and one anaesthetist at the Baffin Regional Hospital, providing services to Nunavummiut. Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. As of March 31, 2007, Nunavut had 127 physicians participating in the health insurance plan.

Physicians can make an election to collect fees other than those under the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2006–2007, no physicians provided written notice of this election. All physicians practicing in Nunavut are under contract with the Department.

Insured physician services—refers to all services rendered by medical practitioners that are medically required. Where insured services are unavailable in some places in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has in place health service agreements with medical and treatment centres in Ottawa, Winnipeg, Yellowknife and Edmonton. These are the out-of-territory sites that Nunavut refers its patients to access medical services not available within the Territory.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service. Then the decision of the group would be presented to Cabinet for approval. No insured physician services were added or deleted in 2006–2007.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the Territory must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999). Billing numbers are provided for billing the Plan regarding the provision of insured dental services. In 2006–2007, three oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance; for example, orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis, but on rare occasions, for medically complicated situations, patients are flown out of the Territory.

The addition of new surgical-dental services to the list of insured services requires government approval. No new services were added to the list in 2006–2007.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include: yearly physicals; cosmetic surgery; services that are considered experimental; prescription drugs; physical examinations done at the request of a third party; optometric services; dental services other than specific procedures related to jaw injury or disease; the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and physiotherapy, speech therapy and psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include: hospital charges above the standard ward rate for private or semi-private accommodation; services that are not medically required, such as cosmetic surgery; services that are considered experimental; ambulance charges (except inter-hospital transfers); dental services, other than specific procedures related to jaw injury or disease; and alcohol and drug rehabilitation, without prior approval.

The Baffin Regional Hospital charges $1,396 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see section 4.2 under Portability). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under sections 3(1), (2), and (3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the Act or regulations in 2006–2007.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in Nunavut, but does not include a tourist, transient or visitor to Nunavut. Applications are accepted for health coverage, and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins the first day of the third month after arrival in Nunavut, but first-day coverage is provided under a number of circumstances (e.g., newborns whose mothers or fathers are eligible for coverage). As well, permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents and a non-Canadian who has been issued an employment visa for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Armed Forces, the Royal Canadian Mounted Police (RCMP) and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Inter-Provincial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province/territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. To streamline document processing, a staggered renewal process was initiated in Nunavut in 2006. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province/territory is required.

As of March 31, 2007, 30,104 residents were registered with the Nunavut Health Care Plan, down by some 1,068 residents from the previous year. Nunavut's population statistics are published by Statistics Canada and include a number of temporary residents who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which was adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months; or the first day of the third month following the establishment of residency in a new province or territory; or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences in Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment. No legislative or regulatory changes were made in 2006–2007 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continuing coverage. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months, upon receiving a written request from the insured person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, as of January 1, 2001.

Nunavut participates in Physician and Hospital Reciprocal Billing. As well, special bi-lateral agreements are in place with Ontario, Manitoba, Alberta and the Northwest Territories.

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Interprovincial Health Insurance Agreements Coordinating Committee. A special agreement exists between the Northwest Territories and Nunavut Territory, which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the Territory. Payment is made to the host province at the rates established by that province.

Out-of-territory hospitals were paid $23,907,398 in the fiscal year 2006–2007.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1) (j) (o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $158 for out-patient care. No changes were made to these rates in 2006–2007.

In 2006–2007, Nunavut paid a total of $1,105 for insured emergency in-patient and out-patient health services to eligible residents temporarily outside Canada.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made to the insured person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital which is expected to be renamed the Qikiqtani General Hospital in the fall of 2007 with the addition of a new hospital facility connected to the current hospital, is located in Iqaluit and currently the only operating acute care hospital facility in Nunavut. (Recently opened regional facilities located in Rankin Inlet and Cambridge Bay, were both designed with acute care capacity.) The hospital currently has 26 beds, (which is expected to increase to 31 beds in the new Qikiqtani General Hospital in 2007–2008) available for acute, rehabilitative, palliative and chronic care services and three stretchers in the emergency room. The hospital has a staff of 87, including 34 nurses and 10 physician positions and in 2006–2007 the process to advertise for and screen staff for an additional 26 new positions was underway in preparation for the opening of the new Qikiqtani General Hospital. The facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, limited intensive care services, and general medical care, maternity and palliative care. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/ otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

In 2006–2007, acute care in Nunavut stayed at a total of 53 beds (35 beds in Baffin Regional Hospital and 9 beds in each of the two regional centres located in Rankin Inlet and Cambridge Bay).

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill, Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency nursing services are provided by all 24 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, basic services were provided in 2006–2007. Nunavut is seeking to increase resources in all areas.

Telehealth services are available in all 25 communities throughout Nunavut. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options and allowing service providers and communities to use existing resources more effectively.

5.3 Access to Insured Physician and Surgical-Dental Services

In addition to the medical travel assistance and Telehealth initiatives, Nunavut has in place, agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. The Telehealth network, linking all 25 communities, allows for the delivery of a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education. In 2006–2007, Nunavut had 127 physicians registered.

The following specialist services were provided under the visiting specialists program: ophthalmology; orthopaedics; internal medicine; otolaryngology; neurology; rheumatology; dermatology; paediatrics; obstetrics; physiotherapy; occupational therapy; psychiatry; and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

All full-time physicians in Nunavut work under contract with the Department of Health and Social Services. The terms of the contracts are set by the Department. Visiting consultants are either paid on a per-diem basis or fee-for-service.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital, the two new regional facilities in Rankin Inlet and Cambridge Bay, and the 22 community health centres, are part of the Department's budget as represented in the budgets for regional operations. No payments are made directly to hospitals or community health centres.

6.0 Recognition Given to Federal Transfers

Recognition of Canada Health Transfer by the Government of Nunavut for 2002–2003 through to 2004–2005 was given when the "Medical Care Act Annual Report 2005–2006" was tabled in the Nunavut Legislative Assembly on November 27, 2006.

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care

Adult Residential Care Facilities are located in a total of seven communities with a total of 64 beds, and serve the needs of Nunavummiut through a mix of predominately privately owned service providers and one publicly-owned and operated facility. Licensing agreements are in place to provide for the leasing of the publicly-owned facilities. Each facility welcomes both male and female clients and offers Level III or Level IV type care on an indeterminate basis. Most facilities offer respite services and nursing services on an "as needed" or on a regular (8 hour/day and thereafter on-site) basis. Personal care is provided to all residents on a round-the-clock basis, with home care services generally offered on an as-needed basis. Rehabilitation services (Physiotherapy, Occupational Therapy and Speech-Language Pathology) are offered to residents ranging from six to 36 visits per year, depending on the facility.

No legislation currently exists in Nunavut to formally enable the activities provided in the above-mentioned extended health care facilities.

Intermediate care is available at Naja Isabelle Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are available between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat Elders Homes. These facilities provide the highest level of long-term care in Nunavut; that is, extensive chronic care services up to the point of acute care (levels IV and level V) services. Acute care cases are transferred to the closest hospital.

Home Care Services

The Home Care Program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency and supports family members and community involvement to enable individuals to remain safely in their own homes.

During 2006–2007, home care in Nunavut included a full array of services; including nursing and personal care, respite care, palliative care, elders programs and home-making services (which generally represent the majority of service hours provided). In addition, rehabilitation services in the form of physiotherapy and occupational therapy are offered to clients on an "as needed" basis.

Home and Community Care (HCC) program standards are developed by a territorial HCC Coordinator through Regional Home and Community Care Managers—one located in each of the three Regions of Nunavut—who report operationally to the Executive Director in each Region. Home Care Nurses in each community in turn, report to the Managers. Home Care support staff (which include Home & Community Care Representatives and Home & Community Care Workers) report to their respective Home Care Nurse. In communities in which Home Care Nurses are not present, support staff report to the Supervisor of the local Health Centre. (Health Centre Supervisors in turn report to their respective Regional Executive Director, who is in turn, directly accountable to their respective Home and Community Care Manager).

Due to human and fiscal constraints, limitations have been noted in some communities. As such, services offered in communities are not consistent across the Territory.

Ambulatory Health Care Services

In 2006–2007, ambulatory health care services were not offered across Nunavut.

However, to address this, a proposal was tabled in the November 2006 sitting of the Legislative Assembly, it recommended the approval of a *Continuing Care Plan*; the construction of four new continuing care facilities over the next four years; the development of a *Healthy Living Strategy* for elders (intended to decrease illness and the onset of diseases that may become chronic for the elderly); the increase of Home and *Community Care Services* to support independent living; the expansion of the *Supportive Living* Stream, intended to provide greater flexibility for seniors (by bridging the gap between living at home with support, and living in a nursing home). Continuing Care Centres are intended to provide facility-based long term care, palliative care, sub-acute care, respite care, wellness and community care programs. Two new continuing care facilities are planned for construction in winter of 2007–08 with materials and designs slated for delivery in fall and winter of 2006–2007.

Registered Persons					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
1. Number as of March 31st (#).	29,478	31,660	31,525	31,172	30,104

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
2. Number (#):					
a. acute care	1	1	1	1	1
b. chronic care	not available	not available	not available	not available	
c. rehabilitative care	not available	not available	not available	1	1
d. other	25 [1]	25 [1]	25 [1]	26 [1]	26
e. total	not available	not available	not available	28	28
3. Payments for insured health services ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
4. Number of private for-profit facilities providing insured health services (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
6. Total number of claims, in-patient (#).	2,524	2,526	2,544	2,721	2,644
7. Total payments, in-patient ($).	18,640,982	17,202,646	15,851,159	17,909,264	20,572,287
8. Total number of claims, out-patient (#).	10,677	12,112	14,492	16,939	14,540
9. Total payments, out-patient ($).	1,740,038	1,552,418	2,521,841	3,596,878	3,335,111
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	0	2	1	1	0
11. Total payments, in-patient ($).	0	6,300	6,345	954	0
12. Total number of claims, out-patient (#).	3	2	1	16	5
13. Total payments, out-patient ($).	982	400	433	2,637	1,105

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[1] This includes 22 community health centres and two regional health centres located in communities throughout the territory; and a public health unit and a family practice clinic, located in Iqaluit. The family practice clinic has nurse practitioners (NPs) and a physician offering primary health care, as it would if located in one of the communities and operating as a community health centre.

Insured Physician Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
14. Number of participating physicians (#):					
a. general practitioners	106	75	86	74	60
b. specialists	80	64	82	61	67
c. other	0	0	0	0	0
d. total	186	139	168	135	127
15. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
16. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
17. Services provided by physicians paid through all payment methods:					
a. number of services (#)	not available	not available	not available	not available	not available
b. total payments ($)	not available	not available	not available	not available	not available
18. Services provided by physicians paid through fee-for-service: [2]					
a. number of services (#)	65,532	60,561	59,542	57,363	46,368
b. total payments ($)	3,336,866	3,548,457	3,112,661	2,863,075	2,380,746

Insured Physician Services Provided to Residents in Another Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
19. Number of services (#).	43,064	51,050	45,334	57,332	59,121
20. Total payments ($).	2,674,445	2,955,996	2,816,282	3,471,307	3,623,163
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	1	19	0	36	5
22. Total payments ($).	8	1,519	0	2,459	1,105

Insured Surgical-Dental Services Within Own Province or Territory					
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
23. Number of participating dentists (#).	not available	not available	not available	not available	not available
24. Number of services provided (#).	not available	not available	not available	not available	not available
25. Total payments ($).	not available	not available	not available	not available	not available

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[2] Nunavut does not pay physicians through fee-for-service. Instead, the majority of physicians are compensated through salaries and alternative methods. Information on salaried physicians is reported via the shadow billing process. Figures include shadow billed claims.

ANNEX A

Canada Health Act and the Extra-Billing and User Charges Information Regulations

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original act, which includes any amendments that have been made since the Act's passage. The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations. These regulations require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. These regulations are also presented in an office consolidation format. This unofficial consolidation is current to June 2001.

CANADA

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health serv-

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

ices throughout Canada by assisting the provinces in meeting the costs thereof;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *« dentiste »*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *« services complémentaires de santé »*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" *« surfacturation »*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *« régime d'assurance-santé »*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *« professionnel de la santé »*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *« hôpital »*

"hospital" includes any facility or portion thereof that provides hospital care, including

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

« assuré » "insured person"

« assuré » Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la Loi sur le système correctionnel et la mise en liberté sous condition;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

« contribution » [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » "cash contribution"

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces.

« dentiste » "dentist"

« dentiste » Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

« frais modérateurs » *"user charge"*

« frais modérateurs » Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services"
« services hospitaliers »

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services"
« services de santé assurés »

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" means, in relation to a province, a resident of the province other than

« habitant »
"resident"

« habitant » Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

« hôpital »
"hospital"

« hôpital » Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

« loi de 1977 » [Abrogée, 1995, ch. 17, art. 34]

« médecin »
"medical practitioner"

« médecin » Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

« ministre »
"Minister"

« ministre » Le ministre de la Santé.

« professionnel de la santé »
"health care practitioner"

« professionnel de la santé » Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

« régime d'assurance-santé »
"health care insurance plan"

« régime d'assurance-santé » Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

« services complémentaires de santé »
"extended health care services"

« services complémentaires de santé » Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

« services de chirurgie dentaire »
"surgical-dental services"

« services de chirurgie dentaire » Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

"insured person" *« assuré »*

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" *« médecin »*

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" *« ministre »*

"Minister" means the Minister of Health;

"physician services" *« services médicaux »*

"physician services" means any medically required services rendered by medical practitioners;

"resident" *« habitant »*

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" *« services de chirurgie dentaire »*

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" *« frais modérateurs »*

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c.8, s. 32; 1999, c. 26, s. 11.

CANADIAN HEALTH CARE POLICY

« services de santé assurés » "insured health services"

« services de santé assurés » Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

« services hospitaliers » *"hospital services"*

« services hospitaliers » Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

« services médicaux » *"physician services"*

« services médicaux » Services médicalement nécessaires fournis par un médecin.

« surfacturation » "extra-billing"

« surfacturation » Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

6. [Repealed, 1995, c. 17, s. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

1984, c. 6, s. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Abrogé, 1995, ch. 17, art. 36]

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health servic-

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

es provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), « services de santé assurés facultatifs » s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)c) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa a), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa b), sauf par une loi de la province.

1984, ch. 6, art. 12.

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre (*b*) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

MANQUEMENTS

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

EXTRA-BILLING AND USER CHARGES

conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Nouvelle application des réductions ou retenues

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

SURFACTURATION ET FRAIS MODÉRATEURS

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

RÈGLEMENTS

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a*) à *d*) de la définition «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13a) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13b).

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)a) ou b) qu'avec l'accord de chaque province.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the Federal-Provincial Fiscal Arrangements Act, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

REPORT TO PARLIAMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)a) s'ils sont sensiblement comparables aux règlements pris en vertu de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces, dans sa version précédant immédiatement le 1er avril 1984.

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)c) ou d) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

RAPPORT AU PARLEMENT

Rapport annuel du ministre

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(a) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the Extra-billing and User Charges Information Regulations.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; (*Loi*)

"Minister" means the Minister of National Health and Welfare; (*ministre*)

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. (*exercice*)

TYPES OF INFORMATION

3. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13a) DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

« exercice » La période commençant le 1^er^ avril d'une année et se terminant le 31 mars de l'année suivante. (*fiscal year*)

« Loi » *La Loi canadienne sur la santé*. (*Act*)

« ministre » Le ministre de la Santé nationale et du Bien-être social. (*Minister*)

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(*a*) in respect of the estimates referred to in paragraphs 3(*a*) and 4(*a*), before April 1 of the fiscal year to which they relate; and

(*b*) in respect of the financial statements referred to in paragraphs 3(*b*) and 4(*b*), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(*a*) and 4(*a*) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a*) et 4*a*), avant le 1^er^ avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b*) et 4*b*), avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3a) et 4a), avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

ANNEX B

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985

OTTAWA, K1A 0K9

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act*. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role—both financial and otherwise—to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the *Canada Health Act* is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act.*

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme *per se* is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act.*

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act.* These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;
2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act.*

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/ deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act.* It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp

Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system—resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau

Minister of Health

ANNEX C

Dispute Avoidance and Resolution Process Under the Canada Health Act

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/ territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the CHA dispute avoidance and resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the Canada Health Act Dispute Avoidance and Resolution process.

Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act.*

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the Canada Health Act. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and health ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving Canada Health Act disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

Fact Sheet: Canada Health Act Dispute Avoidance and Resolution Process

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

ANNEX D

Glossary of Terms Used in the Annual Report

The terms described in this glossary are defined within the context of the *Canada Health Act*. In other situations, these terms may have a different definition or interpretation.

Term	**Description**
Acute care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Block Fee	This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Diagnostic Imaging:	A procedure that detects or determines the presence of various diseases or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.

Term	Description
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.
Fee-for-service	This is a method of physician payment based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act.* The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the Canada Health Act in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been five applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows for the reciprocal processing of out-of-province or out-of-territory claims for hospital in- and out-patient services from either jurisdiction. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

Term	Description
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Medical Necessity	Under the *Canada Health Act*, the provincial and territorial governments are required to provide medically necessary hospital and physician services to their residents on a prepaid basis, and on uniform terms and conditions. The Act does not define medical necessity. The provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, are responsible for determining which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by the public health insurance plan to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licensed physician to residents of the other jurisdiction. Where a reciprocal billing agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physician	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at provincial or territorial fee schedule rates. The provincial or territorial plans reimburse patients of opted-out physicians for charges up to, but not more than the amount paid by the plan under fee schedule agreement.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician	These are licensed physicians who are enrolled in provincial or territorial health insurance plans.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.

Term	Description
Private (for-profit) Health Care Facility	This is a privately owned health care facility that provides laboratory tests, radiological services and other diagnostic procedures, and pays out dividends or profits to its owners, shareholders, operators or members.
Private (not-for-profit) Health Care Facility:	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures, recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides insured health care services under a provincial or territorial health care insurance plan on an in- or out-patient basis.
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required by a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology, and urology.
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Temporarily Absent	Under the portability criterion of the *Canada Health Act* (section 11(1)(b)), the term "temporarily absent" is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.

Contact Information for Provincial and Territorial Departments of Health

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Prince Edward Island
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P.O. Box 2000
Charlottetown, PE C1A 7N8
(902) 368-6130
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Nova Scotia
Nova Scotia Department of Health
P.O. Box 488
Halifax, NS B3J 2R8
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New Brunswick
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http://www.gnb.ca/

Quebec
Ministry of Health and Social Services
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Ministry of Health and Long-Term Care
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Toronto, ON M7A 1R3
1-800-268-1153
www.health.gov.on.ca

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Alberta Health and Wellness
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1515 Blanchard Street
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Yukon
Health and Social Services
204 Lambert Street, 4th Floor
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Whitehorse, YT Y1A 2C6
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Northwest Territories
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Yellowknife, NWT X1A 2L9
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Nunavut
Department of Health and Social Services
P.O. Box 1000, Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
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